Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Physician/ Month Frances Hillyard Рм 6:11 2012 February Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Crofton Care and Rehabilitation Center Crofton Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Funeral 1 □ M 2 🕱 F Hours 579-30-0325 85 1926 Marshall, Virginia Director Usual Residence of Decedent show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Prince George's College Park 1 X Yes 2 ☐ No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a on the Medical Examiner must be Funeral 4818 Erie Street 20740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Francis Lewis Louise Elizabeth Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorianne H. Folstein / Daughter 1541 Eton Way, Crofton, MD 21114 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 2/28/2012 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part Enfort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Atherosclaratic Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami executed Due to (or as a consequence of): resulting in death) Last sician a Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending phys for use as the the, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s Jas autopsy perform death? certificate 2 🗌 No 1 🗌 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural Accident 5 Pending work 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Bluch

se of death (Item 23a) (Type, Print)

gration

6934

Date filed (Month, Day, Year), FEB 2 9 2012

Registrar
DHMH 17 Rev 06-201

State

1500 FOREST GLEN ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DELROY ANGLIN, M. D.

31. Date filed (Month, Day, Year)

FEB 2 9 2012

D0055148

FEB. 24, 2012

SILVER SPRING, MD 20910

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ 4:31 a^{M} MARCH GEORGE SOLOMON HOLLETT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospitäl Chestertown Kent 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Davs Hours January Maryland 89 1923 Director 214-46-4835 Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No MD Kent Millington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 140 Millington Rd. 21651 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Saltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bridge Carpenter Bridge Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John William Hollett Lillian Elizabeth Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 30865 Chesterville Bridge Rd. Millington, MD.21651 Tina Lusby (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Wesley Chapel Cemetery 3/13/12 Rock Hall, MD. 21. Signa ure o Turleral Se 22 Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 M00510 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Approximate Interval Between Onset and Death . Enter shock, or he Immediate Cause (Final disease or andition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consciuence of To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 No 1 Yes Yes Be 25. Was case referred examiner? medical 26. Place of Death (Check only one) the funeral director, Hospital Other: 1 Tyes 2 3 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man r of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury Natural 5 Pending 2 🗌 No death. Investigation after death Director: / Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 🗌 Homicide determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse within 2 To the F ractioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signature and title of certif 103605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricis 31. Date filed (Month, Day, Year) 1 4 2012 Patrick Shanahan 21620 M.D. 120 Speer Rd Chestertown, 32. Registra 's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 2012 РМ Marsha Ann Jinnette 5:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. Social Security Number '. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 👺 F Hours West Virginia 1170471954 Yrs **Director** 220-62-8758 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2 🔀 No Maryland Calvert Lusby o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 825 Golden West Way 20657 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, an "natural", or iter Medical Examiner Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 H No Specify. White 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmitted. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cashier / Clerk Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ivan Jinnette Alma Snedegar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Fallin / Son 12300 Silver Rock Circle, Lusby, MD 20657 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 02/27/2012 Metropolitan Crematory Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failule. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death h sician/ disease or condition Medical resulting in death) Examiner Se wentiall, list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 24 hours after death. Funeral Director: After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 1 Yes 2 1 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be 3 Suicide
4 Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one and title of certifier 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D58900 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LRW Surratt MD 100 Hospital Road Prince Frederick MD 20678

Registrar

State

31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 MA 1030 Carolyn Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Hours (Month, Day, Year) **Director** 241-64-0549 Yrs 76 1935 Sept. 1, South Carolina Usual Residence of Decede or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director with the Maryland 1 XYes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number items 23a or ner must be n Funeral 20005 United States 1425 N Street NW death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Bace - American Indian 11. Marital Status Examiner Black, White, etc. 6 1 Never Married 2 Married by hours after Maryland 21215-0036 African If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Divorced 4 Divorced Completed <u>American</u> Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Government Health Home Aide 12th Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental F permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ones. ပ Nancy Franklin George Renwrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Washington, DC 4438 B Street SE # 5 Nancy Johnson - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of March 2012 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Landover, Maryland 4 Donation 5 Other (Specify) Harmony 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licenses Som M00560 20019 Luvar 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician 000 disease or condition Medical resulting in death) Due to (or a consequence of): Examiner etر Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed ac burial-trai Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death?
1 ☑ Yes 2 ☐ No autopsy performed? certificate 1 Yes 2 🖵 or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ဂ္ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After a completely filled in by the funer 1- Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) een 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

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32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Russell James, Jr. February 11:30 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 6703 Atwood Street, District Heights Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 🕱 M 2 🗆 F Months Hours 217-70-5960 49 22,1962 Cheverly, Maryland Director September Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 ☐ No Prince George's District Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6703 Atwood Street, 20747 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 🔀 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours. Decartment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Industry Service Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Charles Russell James, Sr. Darlene Grisby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maria Del Carmen Mercado / Wife 7342 Lee Highway, Falls Church, VA 22046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 2/27/2012 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility . Signature of Funeral Service Licenses 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. RAY PEPS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ I me one 5 c hua disease or condition Medical resulting in death) Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗌 No 1 TYes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? 1 Yes 2 No Hospital 4 \(\sum_\) Nursing Home 은 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

h

Salvador Sylvester, M.D., 255 Rockville Pike, Suite 125, Rockville, MD 20850 Date filed (Month, Day, Year) FEB 2 9 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

H55927

2/27/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26 Day Month 02 2012 **Physician** 0914 Paul Arthur Knopfer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Somerford Place Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06/18/1939 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1√2 M 2 □ F Brooklyn NY 073-30-7331 72 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Experience is used be notified at 1 ☐ Yes 2 X No Anne Arundel Gambrills Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with USA 21054 2607 Chapel Lake Drive Apt 109 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I □XYes 2□ No 55-57 fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: White δ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) es 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Med. Elementary/Secondary (0-12) College (1-4or 5+) Retail Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bizer Dorothy Moe Knopfer ൧ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2607 Chapel Lake Drive Gambrills, MD 21054 Allyson Knopfer 20b. Place of Disposition (Name of cemetery, crematory or other p. permit. Pages 1 s
Department of He
Important: If item
any injury or oth Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran'S 03/01/2012 Crownsville,MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Englal Service Licensi Hardesty Funeral Home P.A. Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and the burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Sandeep Pandovc MD 2 8 2012 31. Date filed (I

andore

32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Veteran's Highway Millersville, MD 21108

-27-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb.23,2012 Debbie Elizabeth Logan 3:30A Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Suitland Prince 5002 Mathilda Lane 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral 9. Birthplace (State or Foreign Days 1 □ M 2 🛛 F Months Hours Year. Virginia 224-90-5655 **Director** 1956 18 Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Suitland Prince Georges 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral United States 20746 5002 Mathilda Lane or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🖾 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event the Man College (1-4 or 5+) Elementary/Seconday (0-12) Government Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Settles Nellie Robert Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5002 Mathilda Lane Suitland, MD 20746 Jacqueline Logan (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Resarrection 1 XBurial 2 Cremation 3 Removal from State Mar. 1,2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilities 503 Old HYELS, MD 21. Signature of Funeral Service Licensee K Johnson Funeral Home 20748 Tanen 23a, Part 1, Enter the disease, or somol tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ PCV.Z vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical been signed by the attending physiciar To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X C titiving Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of per 9200 Baril Ch Ske

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) FEB 29

Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death February 22, 2012 Physician/ Raymond Stanley Lewis 6:24 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 Shady Spring Place Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. Sept. 17, 213-56-6933 1949 Washington, DC 62 **Director** 1 **X**M 2 □ F Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. Count 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Montgomery Gaithersburg ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Shady Spring Place 20877 Funeral "natural", or items 23a United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 K Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Company Claims Adjustor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Norman Lewis Josephine Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> and 2 s Health Shady Spring Place, Gaithersburg, MD 20877 Melissa R. Lewis (Daughter) item 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot February 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Frederick, Maryland 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Service M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Intertifie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, si ock, or licent failure. List only one cause on each line.

Immediate Aus Approximate
Interval Between
Onset and Death 15 Minutes Physician/ Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner 15 years Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and Exami Cause (Disease or injury that initiated events requires that the death certificate be executed 15 years Hypertension Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown g 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease 1 Yes 2 No 3 Probably 4 H Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? death? 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, acompletely filled in by the funeral director, 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🙀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Ny'se Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Ø February 24, 2012 D 21340

State

Registrar

Raymond /A. Bass, M.D., 15225 Shady Grove Road, #302, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28 2012

Registrar's Sign.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 ear Physician/ March 4, 9:45 AM LaSorsa Nellie Gregory Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth

(Month, Day Year)

ne 11,1921 Frederick 2401 Calloway Court <u>Frederick</u> 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 078-34-4437 Puerto Rico 90 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shor 10a. State 10c City Town or Location must be notified at Director MD Frederick Frederick 1X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? ö 23a Funeral 21702 United States 2401 Calloway items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces? or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 er than "natural", c , the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education 5+ Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Enrique Gregory Adela Ouintana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Calloway Ct., Frederick, MD 21702 Valerie Hartman (Daughter) 20b. Place of Disposition (Name of R **கெய்ற கூரும்**ற or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 3/7/2012 Memorial Bardens Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney & Basford P.A. 106 E. Church St., Fre Funeral MO1612 Frederick, Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 mont Year Month Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner 28a. Date of injury (Month, Day, Year) 28b. Time of Death Certificate: 1 Matural 5 Pending Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

amend 23a Pt. I c., per me, g926 4-23-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 0920 Jo Lauman Amv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegan WMHS-RMC umber If Under 2 8. Date of Birth Month, Day, Year Feb 6, 1973 7. Age (In yrs. last birthday) 9. Birthplace State or Foreign **Funeral** Birthpias . Country)MD Months Davs Hours Min. Director 1 □ M 2 □XF 219-11-7578 39 or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Cumberland Allegany MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21502 USA 300 Arch Street Apt. 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian, Black White etc "natural", or þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced white or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) International Beauty School student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kristie Ann Long Joseph Lauman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 300 Arch Street Apt. 2 Cumberland M MD 21502 April Lantz perrep. Idom. part. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Kremation 3 Removal from State 3/8/2012 MD Cresaptown Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between AHUXIC GRAIN INJUNG

Due to (or as a consequence of): Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events Hanging Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: Other: 1 Enpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury
(Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1
Natural 5 Pending work? 2018 2 Accident
3 Suicide 2 No Investigation HENSEL 6 Could not be 28e. Place of Infury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined City or Town, State) EUMBERUNGS Medical

Records, **Division of Vital** Hospital or Attending Physician: filled in by

State Registrar

29a. Certifier

29b. Signature and title of certifier

Michael

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

umberland MD 2150 a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8:31P M Moore February 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 3701 International Drive #259 Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days (Month, Day, Yea April 16, 1 X M 2 T F Country)
Indiana Yrs. 77 220-28-6773 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 No Md Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 International Drive 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No 1952-1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced 1954 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SBA Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold Moore Ann McGuigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassidy Ashley Jagger/Daughter 12033 Coldstream Dr. Potomac Md. 20854 Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Feb. 5 Other (Specify) Metropolitan Crem. 2012 Alexandria, Virginia 4 Donation 22. Name and Address of Facility neral e MO1315 21. Signature DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Acute Coronary Insufficiency 10 Minutes 5 Years Coronary Artery Disease with Bypass Due to (or as a consequence of): greater than Chronic Obstructive Pulmonary Disease 5 years Due to (or as a consequence of): greater than 5 years Diabetes Mellitus Type 2 on Insulin

Physician/ Medical Examiner

and

permit. Page 1 a
Department of H
Important: If ite
any injury or ot

Physician/

Medical

Director

Completed by Funeral

Be

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Examine

Physician/Medical

Completed by

Be

Certificate: To

Medical

4 Homicide

29b. Signature and title of certifier

Bennett Morrison 31. Date filed (Month, Day, Year)

erenel

FEB 29 2012

29a, Certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Examiner

Funeral

Director

ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It if item 22 is marked outher than "natural", or items 23a or 28a-f show or other traunatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

that initiated events resulting in death) Last

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D47682

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2901 Olney-Sandy Spring Rd. Olney, Maryland 20832

Year

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

February 27, 2012

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 X No. 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed by the attending physician tached for use as the burial Division of Vital Records, P.O. Box 68760 been signed by the a should be detached has certificate funeral director, this To the Funeral Director: After completed filled in by the funeral within 24 hours a To the Funeral L To the Hospital

> State Registrar

			State of Maryland / Department		Mental Hyg	giene	00013
			· · · · · · · · · · · · · · · · · · ·	tificate of Death	F	Reg. No. 4 U I 4	. 00013
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
	Medic	al	Phyllis Rose Magno		Februar		11:35 a ^M
	Examir	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dear	
```	Funeral		Holy Cross Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Silver Spring If Under 1 Year I If Under 24 Hrs.	8. Date of Birth	Montgome	thplace (State or Foreign
	Director		114-14-6214 1 □ M 2 ₺ F 87 Yrs.	Months Days Hours Min.	(Month, Day,		untry)
	_ MC		Usual Residence of Decedent		Aug. 5,	1924 N	·
	ylanc -f sho ed at	턍	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	e Mar r 28a notifi	Şire	MD P.G. Silver				1 🗌 Yes 2 🔀 No
	ith th	Funeral Director	3160 Gracefield Road, Unit 1503	10f. Zip Code 20904		10g. Citizen of What Co USA	ountry?
	ath w	nue	11. Marital Status 12. Was Decedent Ever in U.S. 13.		ecify Yes or No-	14. Race - Ame	wioon Indian
ယ	or ite			Was Decedent of Hispanic Origin? (Spi f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black White	e etc
Š	ırsaft ıral", IExal	ed	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	I ☐ Yes 2 ♣ No Specify:		Specify.Whit	e
2	"nate	Completed by	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ina	16b. Kind of Business	/Industry
121	hin 7	E O	Elementary/Secondary (0-12) College (1-4 or 5+)	O NOT use retired)  Assembly	,,,,g	Manufactui	rino
, D	ed wit Hygie Ither	Bec	17. Father's Name (First, Middle, Last)		- (Flora Adi I II- A		
au	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	2	Joseph J. Campanella	18. Mother's Nam  Mary Si		Maiden Surname)	
2	ould I			ng Address (Street and Number or Rura		City or Town State 7	n Codal
Š	12 sh alth ar 27 is rtrau		Tool Hall	Saybrook Avenue,			
ē,	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  Liff item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Dispo	sition (Name of	Date _{n o}	20c. Location - City or	Town, State
Ë	Page 1 nent of ant: If it ury or o		Bullar E E Gromation G E nomovaritom Gtate	natory or other place) Feb ion Cemetery 2	Date 28, 012	Montebello	, CA
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.			Name ind Address of Earlithins	Funeral	Home Inc.	
m	99 E 8 9			00 University Blvd			ng, MD 20901
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
~-	hysician/		Immediate Cause (Final disease or condition Coronary Artery Dis	sease			Onset and Death
	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		er	Sequentially list conditions, if the least sequence of the least s				
	_Β <u>a</u> Ω	min	trany kading temperatura cause. Enter Underlying Cause (Disease or injury				
	be executed sician and burial-transi	Exa	that initiated events c. Due to (or as a consequence of):				
09	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tagsit	dical Examine	d				
9/8	certificate inding physuse as the		IF FEMALE:				
χ 29 ×	r use	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of de	livery
Box	death he att ied fo	sici	1 Yes 2 X No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
o	that the death ned by the atte e detached for	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	ndarlying cause given in Port I	OO. Bidted		
<u>.                                    </u>	es this signed I be d	Completed by	Atrial Fibrillation, Morbid Obesity,			bacco use contribute to	robably 4 A Unknown
ğ	requir	etec	land of the state				
ပ္က	has by ye 2 s	ldm			24a. Was a autops perfori	sy prior to o	topsy findings available completion of cause of
or Vital Records,	n: The ficate or, pag		25. Was case referred to medical		1 Yes		2 🗆 No
ıta	sicial certii lirecto	Be c	examiner?  1  Yes 2  No	26. Place of Death (Check			
10	g Phy er this eral d	e: To	27. Mapner of Death 28a. Date of injury 28b. Time of			ence 6 Other (Spec ow injury occurred	ify)
ב כ	nding ath. r: Afte ne fun	Certificate:	1 Thatural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		,,	
Division	er de:	ərtif	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	eet, factory, office		reet and Number or Ru	ral Route Number,
2	talor rsaft al Dir led in		building, etc. (Specify)		City or Town	n, State)	The state of the s
	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign Completely filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of (Check 2 Medical Examiner: On the basis of examination and/or invest	occurred at the time, date and place, a	nd due to the cau	use(s) and manner as st	ated. cause(s) and manner stated.
	thin 2 thin 2 the 1	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge,	death occurred at the time, date and pla	ace, and due to the	e cause(s) and manner a	s stated.
	8 4 5 4		29b. Signature and title of certifier	29c. License number \$ 5728		29d. Date signed (Month FFB 2	1, Day, Year) 27 2012
			30. Name and address of person who completed cause of death (Item 23a) (Type, F		7	1002	. / 2010
			Anna Korzan, MD 3110 Gracefield R	•	g, MD 20	904	
	Stat	е	31. Date filed (Month, Day, Year)				
	Registra	ır	31. Date filed (Month, Day, Year) FEB 2 9 2012  Registrar's Signaure				

				Please	e Type or Pr								Legible	€.		
			For State Registrar			larylanc		artment of tificate of		and M	1ental Hy	giene Reg. No.	20L	2	08	014
l,	Physicia			ne <i>(First, Middl</i> e, <i>La</i>							2. Date of De Month Februa:		, 2012		3. Time of 4:40	
يتلفقر	Medi Examir		4a. Facility Name (i	if not institution, giv	re street and number)			4b. City, Town, o			100100	4c. C	County of Dea	ath		
	" Funeral		Suburban 5. Social Security N	Hospita		ge (In yrs. las	t birthdav)	Betheso		24 Hrs.	8. Date of Bir		ntgome	-	re (State r	or Foreign
18	Director		449-32-5	911	1 <del>X</del> M 2 □ F	82	Yrs.	Months Days		Min.	(Month, Da	y, Year)	y, Year) Country)			n i oreigii
	nd how at	٦	Usual Residence 10a. State	of Decedent  10b. County		10c. City,	Town or Loc	cation			08/22/	1929	Te	xas	. Inside C	rtv Limits
	Maryla 8a-f s tified	recto	MD	Montgon	mery	Ker	nsingt	on							1X Yes	2 🗆 No
	s 23a or 2 nust be no	Funeral Director	10e. Street and Nui 10213 M	mber ontgomery	y Avenue			10f. Zip Code 20	895			10g. Citize <b>Uni</b>	en of What C Lted S	ountry tat	es	
9036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ted by Fur	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 \( \overline{k} \) Yes 2 \( \overline{k} \) If Yes, Give Year or Dates.	Ever in U.S.  No Kore War	eanl	Vas Decedent of H f Yes, specify Cub			cify Yes or No- Rican, etc.)		1. Race - Am Black, Whi	ite, etc		
21215-0036	hin 72 hou ne. <b>than "natu</b> ie Medica	Completed by	(Spe	15. Decedent's lecify only highest gondary (0-12)		5+)	(Give F	lent's Usual Occu kind of work done O NOT use retired Orney	during mos	t of worki	ng	16b. Kind	d of Business	s/Indus	stry	
Maryland 2	d be filed wit Mental Hygie arked other tic event, th	To Be C	17. Father's Name Harry C.	(First, Middle, Last) McPherso			neco	, incy		er's Name H <b>igh</b>	e (First, Middle, <b>t</b>	Maiden Su				
, Mar	id 2 shouk saith and N n 27 is ma er trauma			ame/Relationship (	Type, Print) on / Wife			g Address (Street								
Baltimore,	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra				Removal from State	cer	netery, cren	sition (Name of natory or other pla Cremato:			Date -2012		ation - City o			
Balt	permit. Departr Import. any inji	. 99	21. Signature	eral Service Licer	100			. Name and Addre								
- John F	hysician/		23a. P rt 1. Anter to shock, or hea Immediate Cause disease or condition	(Final	nplications that cause one cause on each lin Subdura1			r the mode of dyir	ng, such as	cardiac o	r iratory ar	rest,	_	In	oproximat terval Bet nsepand I	ween
-	Medical Examiner		resulting in death)  Sequentially list co	ſ	Due to (or as	a cons_ ue	nce of):		- 2	<u> </u>	1).	W	DA	1	<del>h</del>	
	executed an and rial-transit	Examine	if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate erlying injury	Due to (or as	a consequ	ce of):		6	K			1.2			
		<u>=</u>	resulting in death)	Last	Due to (or as	a conseque	nce of):	X.	4		8	5.2	112			
. Box 68760	Physician; The law requires that the death certificate be this certificate has been signed by the attending physici yral director, page 2 should be detached for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months?	23c. If yes, outcome 1	2 Fetal of	death 3	Ectopic pregnan Other (specify)	су			23	d. Date of de Month	elivery Da	y ì	/ear
ds, P.O.	v requires that to been signed be should be deta	à	Part II. Other signif	ficant conditions of	contributing to death b	out not result	ting in the ur	nderlying cause gi	ven in Part	l. 			contribute to			
of Vital Records,	The law recate has be page 2 she	Completed									24a. Was autor perfo 1  Yes	osy rmed?	24b. Were au prior to death? 1 🔲 Ye	compl	etion of c	
ital	ysıcıan: Ine s certificate director, paç	Be	25. Was case referrence examiner? 1 X Yes 2		Hospital:			Oth	lace of Dea	th <i>(Check</i>	only one)					
of V	g Pnys er this neral di	e: To	27. Manner of Deat	h	28a. Date of inju	ient 2 🗆 Ef	8b. Time of	28c. Injur	4 LJ No yant		me 5 🗌 Resid 8d. Describe h			cify)		
lo	eath. or: Afte	ficat	1  Natural 2  Accident 3  Suicide	5 Pending Investigatio		), Year) 012 1	0:00	P M 1 □	∢? Yes 2 🔀	No :	Fall					
Division	ital or Att its after d al Directo led in by 1	al Certificate:	4 Homicide	6  Could not be determined			e, farm, stre	et, factory, office		- 1	28f. Location (S City or Tow			_		ry
:	or the hours after death, within 24 hours after death.  3 To the Funeral Director: After this or the Funeral Director, the funeral director after the funeral director.	Medical	(Check 2 only one) 3	Medical Exam	vsician: To the best of niner: On the basis of e se Practitioner: To the	xamination a	nd/or investi	gation, in my opini- death occurred at	on, death oo the time, da	place, an	d due to the ca	use(s) and nd place, ar	manner as s nd due to the	tated. cause(	s) and ma	nner stated.
	25 Parith		29b. Signature and	title of certifier	mus	end	4	29c. Licens	75	91			igned (Mont / 2012	th, Day,	Year)	
_			30. Name are activ	ers of person who Muench M		1d Geo	orgeto	wn Road	Bethe	sda,	MD 208	314				
	Stat Registra		31. Date filed (Mont.	h, Day, Year) 3 2 8 2012	82. Registra	ar's Signatur	par	J.								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				epartment of Health and N	Mental Hygie	ene
				Certificate of Death	Re	g. No. 2012 08015
П	Physicia	ın/	1. Decedent's Name <i>(First, Middle, Last)</i> John J. McHugh		2. Date of Death Month	Day. Year
يا والمادي	Medic	al			February	1
	Examin	er	4a. Facility Name (if not institution, give street and number) Sanctuary at Holy Cross	4b. City, Town, or Location of Death Burtonsville		4c. County of Death  Montgomery
1	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth	9. Birthplace (State or Foreign
	Director		080-24-0893 1™ 2□F 80 Yrs	Months Days Hours Min.	(Month, Day, Y	(ear) Country)
	p on	L	Usual Residence of Decedent		June 15,	
	ırylanı I-f sh ied a	cto		Location		10d. Inside City Limits 1 ☐ Yes 2 ĀNo
	or 282	Director	MD Montgomery Burt	onsville 10f. Zip Code	1.10	g. Citizen of What Country?
	with til 23a c st be	eral	3415 Greencastle Road	20866	10	
	eath v	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA  14. Race - American Indian,
98	fter d	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  Armed Forces? 1 M Yes 2 No If Yes, Give Korean Year or Dates.	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc.
8	ours a tural' al Ex	ted	Out it it			Specify:White
5	72 hc n "na Aedic	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)	ing 10	6b. Kind of Business/Industry
212	vithin giene. er tha the A		Elementary/Secondary (0-12)   College (1-4 or 5+)	Probation/Parole (	Officer	Federal Government
p	filed valued by all Hyg	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	
ylai	ld be Menta arked	입	John Joseph McHugh	Cathe	erine Cro	nin
Mar	should be filed within 72 h and Mental Hyglene. 7 is marked other than " traumatic event, the Med			ailing Address (Street and Number or Run		
e,	and 2 Health em 27 ther t			09 Vandalia Drive,		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		14XBurial 2 Cremation 3 Removal from State cemetery, of	crematory or other place)   Man	ch l	Oc. Location - City or Town, State
킆	artmer artmer ortant injury		4 Donation 5 Other (Specify) Gate of  21. Signature of Euneral Service Licensee	Heaven Cemetery	2012 S	ilver Spring, MD
Ba	permit Depar Impor any in			22. Name and Address of Facility Francis J. Collins 500 University Blvd	Funeral 1	Home Inc.
			I 23a. Part 1. Enter the disease, or complications that caused the death. Do not	500 University Blvd enter the mode of dying, such as cardiac	or respiratory arrest	Approximate
	Physician/	8 6	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Bilateral Aspirati	on Pneumonia		Interval Between Onset and Death
	Medical		disease or condition resulting in death)  Due to (or as a consequence of):	on incamonia		10 days
	Examiner	<u>.</u>	Sequentially list conditions, b.			
	D 10	nine	if any, leading to immediate Due to (or as a consequence of):			
	and and	xar	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
0	icate be executed physician and st the burial-tan	edical Examiner				
P.O. Box 68760	icate g phys		d			
88	eath certifica attending p	N/ne	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	2 Catania programa		23d. Date of delivery
Bo	death	sicie	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month Day Year
o.	at the	Physician/M	g ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	o undorluing ocupa diven in Deut I		
٠ <u>٠</u>	requires that the des been signed by the s should be detached	Completed by	COPD, Kyphoscoliosis, Acute Renal F	, ,		cco use contribute to the cause of death?  2 🖾 No 3 🗆 Probably 4 🗀 Unknown
Division of Vital Records,	requir	etec				
ဝင္ပ	e law has l	<u>m</u>	Esophageal Stricture		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	I or Attending Physician: The law after death.  Director: After this certificate has the in by the funeral director, page 2.		25. Was case referred to medical	26. Place of Death (Check	1 ☐ Yes 2X	
Vita	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 🛣 No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othorn		ce 6 Other (Specify)
of	<b>ng Ph</b> ter thi		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	28d. Describe how	
0	eath. or: Af the fu	Certificate:	2 Accident Investigation	M 1 Yes 2 No		
NIS.	or Att	Serti	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Ō			29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th coordinated at the time at the state		
	e Hos 124 h e Fun letely	Medical	(Check only one) Certifying Princial: To the basis of examination and/or in only one) Certifying Nurse Practitioner: To the best of my knowled	estigation, in my opinion, death occurred at	the time, date and p	place, and due to the cause(s) and manner stated.
			29b. Signature and title of certifier	29c. License number		L. Date signed (Month, Day, Year)
	6+1		> K- thyamondan	D53367		Feb. 26, 2012
•			30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print) #117		
			Shyamsundar Rajan, MD 9801 Georg	ia Avenue, Silver Si	oring,MD	20902
	Stat Registra	_	31. Date filed (Month, Day, Year) FEB 2 8 2012  Registrar's Signature	white		
-			APP 17			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2/25/2012 Physician/ 0250 М CALVIN EDWARD MAHONEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery Medstar Montgomery Medical Center If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Hours Director 1**X** M 2 □ F 577-44-0575 12/3/1931 MD 80 iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Silver Spring MD Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 20906 14412 Bel Pre Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2X No Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give 3 ₩ Widowed 4 □ Divorced Year or Dates Black injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Holy Redeemer Custodian-Catholic School Maintenance and Mental Hygie is marked other 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irene Johnson Robert Mahoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 14412 Bel Pre Drive, Silver Spring, MD 20906 Marchketa N. Ellison/daughter Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/3/2012 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) incoln Park Cem. 22. Name and Address of Facilit Snowcen Funeral Home 21. Signatur 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Mrs Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseque P Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last buria attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a ld be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b oronary Artery Disease Completed 2 No 3 Probably 4 Unknown page 2 should iongestive Heart 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pendina within 24 hours after death.
To the Funeral Director: Al 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar Prince

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18/01

Nicholson

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ McGrath February 2ªy . 6:09A Michael В. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 234 Ebb Point Lane Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** 1 X M 2 □ August 4,1970 Pennsylvania Director 198-60-6978 41 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a USA 21401 234 Ebb Point Lane nit. Page 1 and 2 should be filed within 72 hours after death vartment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Vice President Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ McGrath Marlene Fetchero Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 Ebb Point Lane, Annapolis, MD 21401 Patricia A. McGrath/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem'l Gardens 3/3/2012 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur Funeral Service Licenses 2973 Solomons Island Rd., Edgewater, MD 21401 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Immediate Cause (Final Ph_sician hset and Death NEW TAKES disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner que tially fist no iditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last ng physician a as the burial-t Physician/Medical P.O. Box 68760 attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death Day Year the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2/XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has h director, page 2 s perform 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 1 🗌 Yes ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 🗆 Certifying-Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sigr 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year bur 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Park deventist Washington  $\alpha$ koma lontgomery 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 📉 M 2 🗆 F Days Min. Months 10-06-1937 WASH'. Yrs. 579-46-3380 **Director** 74 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Director notified MD PRINCE GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 3713 LEEDS DRIVE 20746 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ò þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Completed 3 Widowed 4 Divorced Specify: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)
DENTAL X—RAY TECHNICIAN al Hygiene. I other than " Elementary/Seconday (0-12) 2^{Colle} # A1R4Sr 5+) WALTER REED MED. CEN. ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL B. McCOTTRY, SR. ANNA FREEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau JEANNETTE W. McCOTTRY--WIFE 3713 LEEDS DRIVE SUITLAND, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State LINCOLN' MEMO Oth CEN 3-3-2012 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee PINCKNEY-SPANGLER F. H. 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. e my e of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) -Oronar Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Exami -transit that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 attending physician Physician/Medical Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nnknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed Yes 2 within 24 hours are resth.

To the Funeral Director. After this certificate Pompleted filled in by the funeral director, page 1 Tes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 006742

3. Time of Death

DC

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

2012

20912

Z3.

Takoma

1 XYes 2 No

9: 45 AM

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person

reorge PEB 2 9 2012 Но

MO

7600 Carroll

who completed cause of death (Item 23a) (Type, Print)

32, Regis rar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year Month **Physician** 3 2-25-2012 Calvin Percy Martin /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PG 9116 Jousting Lane Upper Marlboro If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Director 579-52-1647 71 12/28/1940 Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at MD 1x Yes 2 □ No PG Upper Marlboro Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 9116 Jousting Lane 20772 US itams 23a death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 21 No Specify: Black Specify: Completed by 3 ☐ Widowed 4 € Divorced "natural", or than "nature." 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Drug and Alcohol Counselor Private other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Health and Mental is marked Percy Martin Cozelle Lawrence ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Buie/ Daughter 9116 Jousting Lane, Upper Marlboro, MD 20772 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Riverdale Park Crematory 2/29/1012 Riverdale, MD * 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes, P.A. 21. Signature of Funeral Service Light 22. Name and Address of Facility 5538 Marlboro Pike, Forestville, MD 20747 Part I. Inter the disease, or complications that caused the death, shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Box 68760, physician Physician/Medical as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No o the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ pe 21 No 3 🔲 Probably 4 | Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed2 certificate 1 Yes 2 No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Certification; To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Watural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 10403 Hospital Dr. 5#103 Winton, Md. 20735 31. Date filed (A th. Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2145 M rances Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min April 18 1941 Director 218-38-7217 1 □ M 2 🔀 F 70 Maryland Usual Residence of Decedent 28a-f show 10c. City. Town or Location must be notified at Director 10d. Inside City Limits MD Anne Arundel Crofton 1 X Yes 2 No 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 1530 Danewood Court U.S.A. 21114 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 14. Race - American Indian, 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Specify Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Real Estate 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Herman Schultz Ella O'Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Donna Marvel Boswell (daughter) 10825 Yellow Dahlia Dr. Woodstock, MD. 21163 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 Donation 5 Galena Cemetery 3/7/12 Galena, MD. Other (Specify) of Funeral Se 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he irt failure. List only one cause on each line Interval Between Immediate Ca e (Final disease or condition Physician/ Onset and Death Small Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p ves, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

Compared at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? Month Day Yes 2 No signed by the a 1 Yes 2 1 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t autopsy performed? death? Hospital or Attending Physician: The 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 1 🗌 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this
y filled in by the funeral di 7. Manner of Death 28a. Date of injury (Month, Day, Year) <u>e</u> 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Certifical 1 Yes 2 No Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

Registrar

DHMH 17 Rev 06-2011

Parhi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2001

ve (1

31. Date filed (Month, Day, Year)

4 2012

03-06-2012

				f Maryland / Dep	artment of Hea	alth and Me	ental Hyg	iene			
			State Registrar	Cei	rtificate of Dea			eg. No. 20	2 0802		
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Lila  L.	Norman			2. Date of Death				
	Examir		4a. Facility Name (if not institution, give street and num 5105 Newport Avenue	ber)	4b. City, Town, or Loc Bethesda		4c. County of Death  Montgomery				
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □ M 2 1 □	7. Age (In yrs. last birthday)		Under 24 Hrs. 8 Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)				
		L.	Usual Residence of Decedent  10a, State  10b. County	84 Yrs.	cation		03/13/1	927 Wasl	ington, DC  10d. Inside City Limits		
	Marylar 28a-f sl otified	Director	MD Montgomery	Bethesda					1 🌠 Yes 2 □ No		
	with the 23a or	Funeral D	10e. Street and Number 5105 Newport Avenue		10f. Zip Code 20816			10g. Citizen of What Country? United States			
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rigury or other traumatic event, the Medical Examiner must be notified at once.	b	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes  If Yes, Give	2 🗗 No	Was Decedent of Hispa If Yes, specify Cuban, N		fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.		
15-00	72 hours n 'natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during O NOT use retired) AC	n na most of warking Iministra	ator	16b. Kind of Business/			
212	within giene. er tha t, the I		Elementary/Secondary (0-12) College (1-12)	4 01 3+)	Eastern Air			Airline			
Baltimore, Maryland 21215-0036	id be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last)  Lawrence Lathrop			. Mother's Name ( Lois Star		flaiden Surname)			
Mar	2 shou Ith and 27 is m traum		19a. Informant's Name/Relationship (Type, Print)  Linda Norman / Daughter	111	ng Address (Street and Newport Av			City or Town, State, Zip	Code)		
ore,	of Hea fitem		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from	20b. Place of Dispo	osition (Name of matory or other place)	Dar		20c. Location - City or	Town, State		
ţim	t. Page tment rtant: I		4 Donation 5 Other (Specify)	Parklawn	Mem. Park	03/03/		Rockville			
Bal	Depar Depar Impo any ir		21. Signature of uneral Service Licensee	5	130 Wiscons	sin Ave.	NW Was	er's Sons hington, D			
	Ph _J sician/ Medical Examiner		resulting in death)  Due to (	aused the death. Do not ent ch line. Static Lung C or as a consequence of):		uch as cardiac or r	respiratory arre	st,	Approximate Interval Between Onset and Death		
90	te be executed nysician and he burial-transit	lical Examine	cause. Enter Underlying Cause (Disease or Injury that initiated events	or as a consequence of):							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affar death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year		
. P.O	es that tigned by	by	Part II. Other significant conditions contributing to de	eath but not resulting in the u	ınderlying cause given i	in Part I.		pacco use contribute to	the cause of death?		
ords	v require s been si s should	Completed					24a. Was ai	24b. Were aut	opsy findings available		
Rec	: The lav cate has ; page 2			= 0.11			autops perform 1 Yes	ned? death?	completion of cause of		
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital:	npatient 2  ER/Outpatie	_ Other:	of Death (Check o		ence 6 Other (Speci	fv)		
n of	ding Ph th. After thi funeral		27. Manner of Death  1 Natural 5 Pending  28a. Date of (Mont)		28c. Injury at work?			w injury occurred			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	l Certificate:		of Injury - At home, farm, str g, etc. (Specify)			3f. Location (Sti City or Town	reet and Number or Rui , State)	al Route Number,		
	To the Hospital within 24 hours a To the Funeral to	Medical	29a. Certifier (Check only one)  1	s of examination and/or inves	tigation, in my opinion, d	leath occurred at th	ne time, date an	d place, and due to the o	ause(s) and manner stated.		
	To the within to the comp		29b. Signature and title of certifier	Louis MIN	29c. License nur 25992		2	9d. Date signed (Month) 02/24/2012			
			30. Name and address of person who completed cause			104 177-9		DC 20000			
	Stat		Daniel V. Young MD 453 31. Date filed (Month, Day, Year) /32. Re	egistrar's Signature		tu4 washi	ington,	20008 טע			
	Registra	ar	FEB 29 2012	w B. Alan							

# Physicia Medic **Examin** Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	Ple	ase Type or Pi								gible.			
	For State	State of N	/laryland / De	partment <i>ertificat</i> e			and IV	, ,	06	112	08022		
	Registrar  1. Decedent's Name (First, Midd	lle, Last)			OID	Calli		2. Date of Deat	eg. No. /		3. Time of Death		
ı/ al	Albert Mald	onado Natal						Month	Day 2-3	Year ZOI	2 1700 M		
r	4a. Facility Name (if not institution	on, give street and number)		4b. City, To	own, or	ocation c	of Death		4c. Count	y of Death	1		
d	Hospice Of Th			wood			8. Date of Birth	An		rundel			
	5. Social Security Number	6. Sex 7. A	7. Age (In yrs. last birthday)			If Under Hours	Min.	Year)		hplace (State or Foreign Intry)			
	Usual Residence of Decedent	XWZDF	1 X M 2 □ F 89 Yrs.					Apr 4 ]	922	922 Puerto Rico			
ctor	10a. State 10b. Count	У	10c. City, Town or					_			10d. Inside City Limits		
Dire	Maryland Pri	nce Georges	Laı	nham 10f. Zip (	O+do				0.000		1 XYes 2 No		
sra	7313 Lois La	ine		101. 2.10		0706		'	0g. Citizen of	J.S.A			
Fune	11. Marital Status	12. Was Deceden	t Ever in U.S. 1	3. Was Decede If Yes, specif			gin? (Spe	cify Yes or No-	14. Rac	ce - Amer	ican Indian,		
by	1 ☐ Never Married 2X Ma		No				, Puerto i	Rican, etc.)	1	ick, White	, etc.		
eted	3 Widowed 4 Divorce	Year or Dates.		1 X Yes 2			Puer	to Ricar		Wh	ite		
mple	(Specify only high	ent's Education hest grade completed)	(Gi	cedent's Usual ive kind of work . DO NOT use r	done du		of workin	ng	16b. Kind of E	Business/I	ndustry		
To Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 or	(1)	nitoria	,	ervic	e		Goth	nam C	o.		
o Be	17. Father's Name (First, Middle,	_				18. Mothe	er's Name	e (First, Middle, M	laiden Surnam	ne)			
ř		Maldonado					rgin						
	19a. Informant's Name/Relationship (Type, Print)  Maria Ruiz de Maldonado (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  7313 Lois Lane Lanham, MD 20706												
	Maria Ruiz de  20a. Method of Disposition	Maldonado (V								- City or 3	Town State		
	20a. Method of Disposition  1												
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home												
	> Bunew	Frend						Lanham	_	20706			
ical Examiner													
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	3 🔲 Ectopic pre						ate of deli			
Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknowr		5 ☐ Other (spe	cify)				IVI	onth	Day Year		
d by Pr	Part II. Other significant condit	ions contributing to death	but not resulting in th	e underlying ca	use give	n in Part I			_	acco use contribute to the cause of death?			
Siete								24a. Was an			opsy findings available		
Į Į								autops perforn 1 🗆 Yes 2	ned?	death?	ompletion of cause of 2   No		
De	25. Was case referred to medica examiner?				26. Plac	ce of Deat	h <i>(Check</i>			η.	25 st Care		
2	1 Yes 2 No		tient 2 ER/Outpat			4	rsing Hor	me 5 🗆 Reside	nce 6 Oth		S) CAL		
are	27. Manner of Death  Natural 5 Pend				c. Injury work?	at ′es 2 🗆		28d. Describe how	v injury occur	red			
Certific	3 🔲 Suicide 6 🗀 Could	mined 28e. Place of Ir	njury - At home, farm, : tc. <i>(Specify)</i>			es 2 🗆	-	28f. Location (Str City or Town,	eet and Number or Rural Route Number, State)				
Medical Certificate:	29a. Certifier 1 Certifyir (Check 2 Medical only one) 3 Certifyin	ng Physician: To the best of Examiner: On the basis of ng Nurse Practitioner: To t	of my knowledge, deat examination and/or inv	th occurred at the	he time,	date and	place, an	d due to the caus	se(s) and man	ner as sta	ited. ause(s) and manner stated.		
	29b. Signature and title of certific		4		License		43	20	ld Date signe	d (Month	Day Vear		
	30. Name and address of person	who completed cause of		e, Print) 445 Da	e fes	se.	Hu	4 Ann	Abali	s Mr	21401		
	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		1		/	1 11/100	1 120 .				
	FEB 2 9 2012	them to.	7										

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mildred Patricia Pykosh 22, 2012 February 3:45 рМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Montgomery Hospice-Casey House Rockville If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 181-34-0264 1 🗆 M 2 🔀 F 69 Dec. 16, 1942 PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery 01ney 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 USA 3905 Springarden Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. White þ Yes 2 X No 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Yes, Give Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office Administrator Real Estate Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ John J. Lignelli Mildred E. Ostovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Paul Pykosh/Husband 3905 Springarden Street, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 7 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place, Arlington Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Arlington, VA 21. S' nature of uneral Servi e Licensee Francis J. Collins Funeral Home Inc. Maten 500 University Blvd. W,. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ovarian Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical by Completed

and and The law requires that the death certificate be executed as the burial attending physician Division of Vital Records, P.O. Box 68760 nse for should be detached has page 2 within 24 hours after death.

To the Funeral Director: After this certificate I To the Hospital or Attending Physician: filled in by the funeral

Be ၉

Certificate:

Medical

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Debrah Miller, CRNP

2 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Funeral** 

**Director** 

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ms 23a or

ral", or iten Examiner

"natural"

of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical.

Department of Important: If it any injury or o once.

Ph sician/

Medical

**Examiner** 

notified 28a-f

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year	
Part II. Other significant conditions o	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 🏝 No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1  Yes 2  No	26. Place of Death (Check Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Hon	only one)  Hosp1ce  ne 5 □ Residence 6 🖾 Other (Specify)
27. Manner of Death  1 🔀 Natural 5 🗆 Pending 2 🗀 Accident Investigatio	injury work?  M 1 \( \text{Yes} 2 \( \text{No} \) No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e Place of Injuny - At home form street factory office	8f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exam	vsician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred at the rese Practitioner: To the best of my knowledge, death occurred at the time, date and place.	he time, date and place, and due to the cause(s) and manner stated

29c. License number

R143201

1355 Piccard Drive, Rockville, MD 20850

29d. Date signed (Month, Dav. Year)

Registrar DHMH 17 Rev 06-2011

20

CRN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3:00a 2. Date of Death Physician/ Patrignani Feb. 27,2012 Alice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville **Examiner** 4c, County of Death Montgomery National Lutheran Home 5. Social Security Number 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 142841923 1 M 2 X Copping). Director 185-18-0151 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Rockville Montgomery 1 🗌 Yes 2 🔀 No 10f. Zip Code 20850 10e. Street and Number 10g. Citizen of What Country? Funeral 9701 Veirs Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 72 hours after Yes 2 🛛 No 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Nora Livingston ဂ unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 76051 Tina Ferguson/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 3/2/2012 20c. Location - City or Town, State Sylvan Heights Cem 1 X Burial 2 Cremation 3 X Removal from State Uniontown, PA. 4 Donation 5 Other (Specify) PHTTTP TO THE RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 uneral Service Lio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ End 5+a disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate eause. Litter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🔀 No ed by the detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy certificate ha 1 Yes 2 No Yes 2 No. No. within 24 hours after death.

To the Funeral Director: After this certific apmpleted filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 - Residence 6 - Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Accident☐ Suicide 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in any or light and the cause (s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number

Registrar DHMH 17 Rev 7/2009 Rockville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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00030612

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ ALMER Month February 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 378-22-5750 1 🗆 M 2 🗓 F 85 Aug., 2,1926 Michigan 28a-f show 10a, State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3528 Chiswick Court 20906 United States iral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black White etc. þ 1 Never Married 2 Married be filed within 72 hours after 2 XNo 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes, Give "natural", Completed 3 X Widowed 4 Divorced Specify. White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. e 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Valentine Charles Schmidt Marsades McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Stephen Palmer (Son) 1787 Louisville Lane, Crystal Lake, IL 60014 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot February 20c. Location - City or Town, State Metropolitan Crematory 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 25, 2012 Alexandria, VA 21. Signature of Funeral Service Li leusee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 M00689 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack or hear failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Interval Between Onset and Death Ph sician disease or condition Medical resulting in death) **Examiner** VASCULAR ACCIDENT. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Pregnant at time of death Dav Year the 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performe Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending after death. 1 🗌 Yes within 24 hours after death

To the Funeral Director: / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

10

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Raphael G. Loutoby, M.D., 18101 Prince Philip Drive, Olney, MD 20832

DDO TO 195

20/2

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24 Day Physician/ Month 02 2012 Charlie A. Palmer 12:01A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Cheverly Prince Georges Community Hosp 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) No. Carolina 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, 6-07-1 🕱 M 2 🗆 F Hours 238-62-9292 69 Director 942 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho. 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits ¹XXYes 2 ☐ No MD Prince Georges Suitland 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 20746 USA 6005 Walton Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Widowed 4 X Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry 12 Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Blanche Allen Hawkins John Robert Palmer 19a. Informant's Name/Relationship (Type, Print)  $\operatorname{Daughter}$ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
9411 Presiey Place
Lanham, Maryland 20706 Felicia Palmer-Greene 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03 - 03 - 2012Suitland, MD Cedar Hill Cem. Ralph Awrilfiams, II FuneralService, P.A. 5202 PrincetonsDelightDr., Bowie, MD 20720 23a. Part I. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysiciani Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Advanced Dementia Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Recurrent Stroke attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day Unknown the 1 L Yes 2 L s been signed by the should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aspiration Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Dysphagia certificate has b irector, page 2 sh 24a, Was an autopsy Yes 2X N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🕱 No 욘 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 XER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural injury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51520 02-29-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahrm Pishdad, 1328 Southern Ave., S.E.; Washington, D.C. MD 20032 FEB 2 9 2012 32. Regist State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:19 AM Physician/ Warch Mike (NMN) Pinto, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours 578-22-5177 Usual Residence of Deced **Director** 1 **X** M 2 □ F 86 July 29, 1925 Washington, 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 ☐ Yes 2X No Maryland | Washington Hagerstown 10e, Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 1621 Langley Drive 21740 death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 Ⅸ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black. White, etc. 1 Never Married 2 Married "natural", or by Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify: Year or Dates WWII White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Welding Supply Company <u>Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ٩ Mike (NMN) Pinto, Sr. Rose Artialere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trace. Patricia A Reinmuth, daughter 1638 Langley Drive, Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 - Other (Specify) Hagerstown Crematory Mar. 5, 2012 Hagerstown, Maryland 22. Name and Address of Facility Andrew K. Coffman Funeral Home, 21 Signature of Fyneral Servic License <u>40 East Antietam Street, Hagerstown, MD 21740</u> Part 1 Enter the disease, or complications to shock, or heart failure. List only one cause of ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Acidos Welks Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 1cmi DEM ENTIA burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) hed the 9 Unknown be detac signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 No Yes 25. Was case referred to medical filled in by the funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After 1 Natural 5  $\square$  Pending work? 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within To the 29b. Signature and title of certifie 29c License numbe 29d. Date signed (Month, Day, Year) 4656 2012 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEEN MUN DADIR 16 MD MM Mr AGMA G(+1+2424 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:35 P February 27, 2012 Leah RABINOVICH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Chevy Chase 2712 Spencer Road 8. Date of Birth (Month, Day, Ye) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 98 vrs **Funeral** 097-03-1173 Hours 1 □ M 2**X**□ F Canada Dec. **Director** Usual Residence of Decedent fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State Director Chevy Chase 1 Ves 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20815 2712 Spencer Road Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc Completed by 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🕅 No Specify: If Yes. Give 3 ¥ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Firm Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Esther Leibert Max Feldman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5947 Valerian lane. Rockville, MD 20852 19a. Informant's Name/Relationship (Type, Print) 5947 Valerian Lane, Rockville, MD f Health item 27 Beth Ann Rabinovich, Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Judean Memorial Gardens 02/29/12 Olney, MD 21. Signature of runeral Torchinsky Hebrew Funeral Home 101008 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sici_n/ Multiple Myeloma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) B Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-therest. Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: မ 4 ☐ Nursing Home 5 🛚 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending injury 1 Tes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) February 27, 2012 10 D 0062999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 6224 Montrose Raod, Rockville, MD Petek Donmez, M.D. 31. Date filed (Month, Day, Year)
FEB 29 Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 4:45р м Ken Samuel Radovsky February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10509 Hayes Avenue Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director 053-40-5157 1 🗓 M 2 🗆 F 60 01/24/1952 Massachusetts 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 10509 Hayes Avenue 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Computers Software Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be filed of Health and Mental H fitem 27 is marked ot Frances Abrams Milton Radovsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3610 Underwood Street, Chevy Chase, Maryland 20815 Dan Radovsky - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 02/19/2012 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Lice 11800 New Hampshire Ave., Silver Spring, MD 20904 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List o one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Uremia <u>6 Months</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician a -To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the P.O. signed by Part II<mark>. Other significant co</mark>nd**itions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy performed' death? 2 No Yes 2 X N 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 X Yes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After the Funeral Director: After the Funeral Director after the funeral Director and the funeral Director and the funeral Director and the funeral Director and Director a Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural Accident 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only 29b. Signature nd title_of certifier

Registrar DHMH 17 Rev 06-2011

State

of person who completed cause of death (Item 23a) (Type, Print) M.D.,

2. Registrar's Signature

Jeffrey Perlmutter.

28 2012

31. Date filed (Month, Day, Year)

7188

6420 Montrose Road, Rockville, Maryland 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ February Patricia Ann Robertson 2:10 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2126 Fernglen Way Catonsville Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 213-80-6960 Country **Director** 1 □ M 2 🔀 F 52 03/24/1959 Usual Residence of Decedent MD 28a-f show 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Catonsville Baltimore 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2126 Fernglen Way 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian "natural", or iter Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene ment of Health and Mental Hygiene and triet from "ratural", or and ther traumatic event, the Medical Examilury or other traumatic event, the Medical Examilury 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Richard E. Robertson Mary Jean Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Frederick Road Catonsville, MD Hanna McFadden - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 03/01/2012 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Hypertensive Cerebrovascular Disease years Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ rate has been signed by the atter page 2 should be detached for in the past 12 months? Month Day Year Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes 2 🔀 No 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗶 Residence 6 Other (Specify) Hospital: 2 🔀 No ျာ 1 🗌 Yes the Hospital or Attending Physhin 24 hours after death.
the Funeral Director: After this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D44243 March 1, 2012 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 10 1120 N. Rolling Road Catonsville, MD 21228 Cook, MD 31. Date filed (Month, Park) W. State

DHMH 17 Rev 06-2011

Registrar

Box 68760

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Funeral Director		5. Social Security N 215-46-1 Usual Residence	129	Sex 1 □ M 2 🔀 F	7. Age (	In yrs. Ia 66	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi		15	Cou		or Foreign
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he dea / the a ched f	Jysic	1 ☐ Yes 2 € 9 ☐ Unknown	No	4 ∐ Preg 9 ☐ Unkr		me of de	eath 5∟	Other (spe	ecify)					Moi	nun	Day	Year
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equires een sig nould b	ted											1 🗆	Yes 2	2 X No	3 Pro	bably 4	Unknown
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Physician: The lav r this certificate has aral director, page 2		25. Was case referre	ed to medical						26. Pla	ce of Deat	h (Check	1 U Yes		No 1		2 No	
hysici his cer al direc	잍		No	Hospital:	Inpatient	2 X E	R/Outpatien	t 3 🗆 DO	Other	r:	-1.	me 5 🗆 Res	idence	6 🗌 Othe	er (Specif	y)	
ding P h. After t funera	ate:	27. Manner of Death 1 Natural	5 Pending		of injury th, Day, \		28b. Time of injury	28 M	ic. Injury work?			28d. Describe	how inju	iry occurre	ed		
Atten	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigati 6 Could not determine	be 28e. Place			ne, farm, stre			res Z		28f. Location (			er or Rura	l Route Nur	nber,
ital or urs afte ral Dir illed in				bullal	ng, etc. (							City or To					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	(Check 2	Certifying Pr Medical Exam Certifying No	miner: On the bas	of exam	mination	and/or investi	igation, in m	y opinior	n, death oc	curred at	the time, date	and plac	e, and due	to the ca	ause(s) and r	nanner stated
A3		29b. Signature and	1 11	411	)		, , ,		License	number				ate signed			
90		P (	00	ay.	10				D	667	53			21	26	112	
4-		30. Name and addre	ess of person who ny Capsta					,	Anna	polis	5 , N	MD 2140	)1				
State		31. Deterind Mont	2012				ire//	7			,						
Registra	r	1 50 4 0	Care Jo	Strang)	<b>7.</b> (	7		_						· · · · · · · · · · · · · · · · · · ·			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mar 5 2012 2:25PM M Marie Roby Dorothy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Golden Living Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD **Funeral** Hours Aug 5, 215-20-5913 Usual Residence of Decedent Director 1 M 2 XF 86 28a-f show 10a, State 10b. County with the Maryland items 23a or 28a-f sho ner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 XYes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21502 USA 7 Long Drive hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? Black White etc 1 Never Married 2 Married "natural", or ð Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Completed 3 □xWidowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Celanese Fiber Corp. 12 factory worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Department of Health and Menta Important: If item 27 is marked any injury or other traumations ၉ Mary Julia Schultz Frederick Lewis Brinker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2868 Yarn Court Falls Church VA 22042 Donna Walters 2868 Yarn Court daughte Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saint Mary's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 3/10/2012 MD Cumberland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Parish Home, PA of Funeral Servi Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph. sician/ 1 rubable Azu min disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed the burial-transi Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medica To Be 26. Place of Death (Check only one) Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No filled in by the Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi-

Ugn

State Registrar 625 Kent Ave Ste. 101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr r's Sign

n.1

Gu

2012

31. Date filed (Month, Day, Year)

D0033280

Cumberland, MD 21503

State of Maryland / Department of Health and Mental Hygiene  1 = State State Reg No. 2 0 12 - DNJ McGr. Certificate of Death Reg No. 2 0 12 0 3 3 3											
			Registrar/MFND#7perFH, 2/29/12; BWW, MCO  1. Decedent's Name (First, Middle, Last)	Oct tilled to 01 L	Catri	2. Date of Death Month		3. Time of Death			
	Physicia Medic	al	Cassie Smith.	Tu 01. 7		02 7	Day 2012	4.16pm			
	Examin	er	4a. Facility Name (if not institution, give street and number)  Lawel Regnonal Iforpula		Location of Death		4c. County of Death	Georges			
	Funeral Director		5. Social Security Number 60 Sex 7. Age (In yrs. last bir	rthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthr	place (State of Foreign try)			
	- 1		Usual Residence of Decedent			Feb. 20,					
	aryland a-f sho fied at	Director	10a. State 10b. County 10c. City, Tow	vn or Location				0d. Inside City Limits 1 ☐ Yes 2 No			
	the Man or 28		10e. Street and Number	10f. Zip Code			Citizen of What Cour	itry?			
	th with ms 23; must I	Funeral	9150 Cherry Lane	267			vited S	tates			
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1  Never Married 2  Married  1  Yes 2  Your Status  1  Yes 2  Your Status	13. Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	14. Race - Americ Black, White,				
21215-0036	hours in matura	Completed		a. Decedent's Usual Occup		16b	. Kind of Business Inc				
121	thin 72 ine. than "I	gmo	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give kind of work done of life. DO NOT use retired)  Brick L	-		Private				
	iled within I Hygiene. other tha rent, the N	æ	17. Father's Name (First, Middle, Last)	DITCH	18. Mother's Name	(First, Middle, Maide					
Maryland	uld be filed Mental Hy narked oth	မ	Casie Earl Smith				Samue				
Mar	and 2 should be fill Health and Mental sem 27 is marked ( ther traumatic eve		19a. Informant's Name/Relationship (Type, Print) (Wife) 19 Tawan Smith	b. Mailing Address (Street a	•	2 8	ber, City or Town, State, Zip Code)				
ore,	of Hea of Hea of Item ir other		20a. Method of Disposition 20b. Place	of Disposition (Name of ery, crematory or other place	e) [	Date 20c	. Location - City or To	own, State			
Baltimore,	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Specify)	sapeake	2-2	9-12 6	ettsville,	MD			
Ba	permit. Departr Imports any inji	. 1	21 Signature of Funeral Service Licensee  MD130	22. Name and Address	150n Fun	eral Hon	ne Temp	le Hills, MD			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Ph sician/ Medical Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  a								Onset and Death			
Transmit .	Examiner	L.	Sequentially list conditions, b. Hypertan	sion							
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Usease or injury)	of):							
	ate be executed ohysician and the burial-tansit		that initiated events c. Due to (or as a consequence	of):							
200	cate be physic s the bu	edical	d								
x 687	n certifii ending r use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea	th 3 ☐ Ectopic pregnanc	ÿ		23d. Date of deliv				
Box	ne death the att	Physician/Me	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown    Unknown   Yes 2 ☐ No   Unknown   Unknown				Month	Day Year			
, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and promise the funeral director, page 2 should be detached for use as the burial factor.		Part II. Other significant conditions contributing to death but not resulting				co use contribute to the	ne cause of death?			
ords	requir been s should	letec	Plemal Effusion Dui	hower h	-nuk	24a. Was an	24b. Were auto	psy findings available			
Rec	The lav ate has page 2	Completed by	Selpais, Seizen co. T	the 20m		autopsy performed 1 \(\simeq\) Yes 2 \(\simeq\)	? death?	mpletion of cause of			
ital	sician; certific rector,	Be	25. Was cas referred to medical examiner?  1  Yes 2  No  Hospital: 1 Inpatient 2 FR/C	_ Othe	ace of Death (Checker:		- C - 4				
of V	ig Physter this neral di	te: To	27. Manner of Death 28a. Date of injury 28b.	Time of 28c. Injury work	/ at	me 5 L Residence 28d. Describe how in	e 6 Other (Specify njury occurred	/)			
ion	ttendin death. :tor: Aff	Certificate:	1 Natural 5 Pending (Montin, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, f	M 1 🗆	Yes 2 ☐ No	20f Lanatian (Street	and Number or Rura	I Pourto Numbor			
Division of Vital Records,	al or A s after al Direct		4 Homicide determined 200. Flace of injury = Actionie, in building, etc. (Specify)	arm, street, factory, onice		City or Town, St		Hogte Numbel,			
	Hospi 24 hour Funera eted filk	Medical	29a. Certifier  1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and, only one)  3 Certifying Nurse Practioner: To the best of my knowledge	or investigation, in my opinio	on, death occurred at	the time, date and pla	ace, and due to the ca	use(s) and manner stated.			
	To the within To the	Σ	only one) 3 $\sqcup$ Certifying Nurse Practioner: To the best of my known 29b. Signature and title of certifier	29c. License			Date signed (Month,				
	T		Karunui Mo	D	68782	Dust	02. 23				
			30. Name and address of person who completed cause of death (Item 23a)  Addeds: Karuwui	(Type, Print) Re	gronal	homula		el 20707 MS			
	Sta Registr		31. Date filed (Month, Day Year) FEB 2 9 2012 37 Registrar's Signature	pare	7	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 3:26 REBECCA G SEKYERE  $a^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 Months Davs Nov. Aay, 215-49-0703 Hours Country) 37 1974 Director Ghana Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Marvland Frederick 1 X Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21702 106 Ellingwood Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Business Office Representative Automobile Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Theophilus Graham Alice Otaba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Bright Sekyere / Husband 724 Clopper Rd., Apt. 31, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 R 4 Donation 8 Other (Specify) cemetery, crematory or other place)
Resthaven
Memorial Gardens March Frederick, Maryland 2012 21. Signat Fyreral Service Lice see Resthaven funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a Part 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Poset and Death Immediate Cause (Final disease or condition KIDNEYDURASE Physician/ CHILDNIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 2 🗌 No s been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy page performed? or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital ည 1 🗌 Yes 2 X No Other: 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director, After completed filled in by the funer 28d. Describe how injury occurred 1 🔀 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No □ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29b. Signatur 29d. Date signed (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print) Pacrence, MOUT 1967702WE,

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

		For State of Maryland	/ Department of Health and M	lental Hygier	ne
	_	Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg.	No. 2012 08035
Physic Med		ROBERT L SUGDEN		2. Date of Death	Day Year 3. Time of Death 26 36 PM
Exam	iner	CALVERT MEMORIAL HOSPITAL	4b. City, Town, or Location of Death	ERICICI	4c. County of Death  CALVERS
Funera Directo		5. Social Security Number 145-07-0250 6. Sex 7. Age (In yrs. last 94	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea. 01-31-191	9. Birthplace (State or Foreign Country) New Jersey
nd now	٦	Usual Residence of Decedent	own or Location		
farylar 3a-f sl	Director	MD Calvert			10d. Inside City Limits 1 ☐ Yes 2 🌠 No
the M or 28	흐	10e. Street and Number	Owings 10f. Zip Code	10g.	Citizen of What Country?
n with 1s 23a nust t	Funeral	1116 Ontario Court	20736		USA
r item			13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Baltimore, Maryland 21215-0036  bermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any nitury or other traumatic event, the Medical Examiner must be notified at ance.	ted by	1 ☐ Never Married 2 ☐ Married 1 🛣 Yes 2 ☐ No If Yes, Give Year or Dates. 1943—4	6 1 ☐ Yes 2 💢 No Specify:		Specify: White
15-( 72 hou 1 "nat ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin	g 16b.	. Kind of Business Industry
212 vithin piene. er thar	5	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired) Cartographer	Fe	ederal Government
land he filed vental Hygir event,	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	
ryla uld be I Ment narke natic e	P	John Sugden	Irene		Martwick
Maryl 2 should be lith and Me 27 is mark		Joanne M. Chaney, daughter	19b. Mailing Address (Street and Number or Rural		
of Heal		20a. Method of Disposition 20b. Place	1116 Ontario Court, Ow		20736  Location - City or Town, State
Imor Page 1 ment of tant: If it			etery, crematory or other place) hville Cemetery 03-02	-2012 D	Ounkirk, MD
Baltimol permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Rau	sch Funer	al Home, P.A.
		23a. Part 1. Enter the disease, or complications that caused the death.			
≺Physicin		snock, or neart failure. List only one cause on each line.		respiratory arrest,	Approximate Interval Between Onset and Death
Medical		disease or condition resulting in death)  a.   Due to (or as a consequence)	L INFARCTION  pe of):		
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VICAL RECORDS, ysician: The law requires is certificate has been sig	dwo			autopsy performed?	prior to completion of cause of death?
cian: T	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check of	1  Yes 2	No 1
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rding th. : After e funer	cate	27. Manner of Death  1 Natural 5 □ Pending (Month, Day, Year)  2 □ Accident Investigation	D. Time of 28c. Injury at work?  M 28c Injury at 28c work?  1 □ Yes 2 □ No	d. Describe how inju	ury occurred
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oital or				City or Town, Stat	
Division of Vital Records, F.O. Box 68/60 with the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.  The the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and 3 Certifying Nurse Practioner: To the best of my knowledge.	D/Or investigation in my opinion death occurred at th	a time date and place	no and due to the course(s) and manner stated
To t To t		29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month. Day Year)
2)		30. Name and address of person who completed cause of death (Item 23a	D SUASS		0/94/30/3
15+1		Hypis Mody MD 110	OSO233 Hospital Rd Suite	310 Priv	ree Frederich Mis
Sta Registr		31. Date filed (Wonth, Day, Year) 32. Registra's Signature	6 1		
- negistr	aı	FEB 2.8 2012 - Peneur	D. Barles		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 Evelyn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X I Months Hours Min. 12/26/1920 Mary land 217-16-6321 91 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 No North Beach Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 8924 Erie Avenue 20714 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white Completed 3 X Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natus ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) retail store bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ervin Hann Gertrude Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Bewley, niece P.O. Box 191, North Beach, MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02/27/12 Alexandria, VA Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an earch line. Approximate Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury **Director:** After this certificate has been signed by the attending physician and I in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate being hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 ON D Part A Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis a tamenation and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner

State Registrar

JRW

who completed cause of death (Item 23a) (Type, Print)

			_ For	State of Marylan	d / Depa	ırtment	of Health a	and M	ental Hyg	iene			
			State Registrar		Cer	tificate	of Death		R	eg. No.	PAL	2 08	037
	Dharaisis	_,	1. Decedent's Name (First, Middle, Last,	)					2. Date of Dear Month		Voor	3. Time of	Death
	Physicia Medic		Lunching	g Sun	1				Februar	y 26,	2012	6:03	P.M
	Examin	er	4a. Facility Name (if not institution, give s	treet and number)		4b. City, To	wn, or Location o	of Death		4c. Co	unty of Deat	th	
180			10160 Treble Cour 5. Social Security Number   6. Sec		nat triutta ela ut	Roc	kville Year   If Under 2	24 Hre	8. Date of Birth		ontgor		- Caralan
	Funeral Director			M 2 D F			Days Hours	Min.	(Month, Day,			thplace (State ountry)	or Foreign
			Usual Residence of Decedent	44	Yrs.				July 9,	1967	Ch	ina	
	shov d at	tor	10a. State 10b. County	10c. City	y, Town or Loc	ation						10d. Inside Ci	ity Limits
	Mary 28a-f otifie	Director	Maryland Montgom	ery Ro	ockvil	le						1 🗆 Yes	2 <b>X</b> No
	a or be n	a D	10e. Street and Number			10f. Zip C	ode			l0g. Citizer	of What Co	ountry?	
	th with	Funeral	10160 Treble Cour				850				ed St		
	r iter iner		11. Marital Status  1 Never Married 2 X Married	12. Was Decedent Ever in U.S Armed Forces?			nt of Hispanic Orig Cuban, Mexican			14.	Race - Ame Black, White	rican Indian, e, etc.	
38	after al", o Exam	d by	3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	☐ Yes 2	X No Specify:			Spe	ecify:	sian	
Š	hours natur ical B	Completed	15. Decedent's Ed	ucation	16a. Deced	ent's Usual (	Occupation			16b. Kind	of Business		
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Maryland 21215-0036	shou and is n		19a. Informant's Name/Relationship (Typ	1			Street and Numbe						
o)	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Chun-Fong Jennifer 20a. Method of Disposition		10160 lace of Dispos		e Court,						
			1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crem	atory or oth	er place)	_			Ť	Town, State	_
탪	nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify,	111111	Souls		tery 3	3/3/2				, Maryl	and
Ba	permit. Page Department of Important: If any injury or once.	,	21. Scarture of Fulleral Service License	Chilery!	10 10		Deer Pa					MD 20	877
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	Medical		disease or condition resulting in death)	a. Pancreatic (							_		
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		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):								
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J.	that the ned by the detach	by Pl	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying ca	use given in Part I	1.	23e. Did tol	oacco use	contribute to	the cause of c	leath?
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oro		olet							24a. Was a		4b. Were au	topsy findings	available
Sec.	The lay	Completed							autops perfor	ned?	death?	completion of d	ause or
<u></u>	sician: The law i certificate has t lirector, page 2 s	BeC	25. Was case referred to medical				26. Place of Deat	th (Check		Z XI NO	1 🗀 10.	3 2 110	
<u> </u>	nysici nis ce I direc	일	examiner? 1  Yes 2  No	fospital: 1	ER/Outpatien	t 3 🗆 DOA	Other: 4 $\square$ Nu	ursing Hor	ne 5 🔀 Reside	ence 6 🗆	Other (Spec	cify)	
Division of Vital Records,	ng Pl fter th Inera		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	280	. Injury at work?	- 1	8d. Describe ho	w injury oc	curred		
<u>o</u>	tendii leath. or: Ai the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be			М	1 🗌 Yes 2 🗌						
NIS.	or Att fter d lirect in by	Certificate:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		et, factory, o	office	2	28f. Location (St City or Town		umber or Ru	ral Route Numl	ber,
5	Hospital or Attending Physician: 24 hours after death, Funeral Director, After this certificated filled in by the funeral director,		On O dis A 19th of distribution Physics	International Control of the Control			an diwan what and	-1000 00	-1 -1 to 4h o oo	.a.a/a\ a.a.d v		tatod	
	Hos 24 hc Fun etely	Medical	(Check 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination or Practitioner: To the best of m	n and/or invest	igation, in my	opinion, death oc	ccurred at	the time, date an	d place, an	d due to the	cause(s) and ma	anner stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific Eompletely filled in by the funeral director.	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	, , actacher, lottle pest of fr	., mowieuge,		icense number	o and pid				h, Day, Year)	
	16		Horen	M			D 37142			Febru	arv 2	7, 2012	
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, P	rint)	3,112			- UDI G	j = 1	, 2012	
			Geoffrey Coleman,	M.D., 1355 Pi	.ccard	Drive	, Suite	100,	Rockvi	lle,	Maryla	and 208	50
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	1							
	Registra	ar	FEB 28 2012	Church B.	Mark	1							

FEBRUARY 19,2012 Baltimore, Maryland 21215-0036 SNOWDEN KELVIN P.O. Box 68760 Division of Vital Records.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registra AMEND #24a/bperMD, 3/1/12; BW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ /19/2012 0215 KELVIN EUGENE SNOWDEN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Hospital Rockville If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number Days (Month, Day, Year) Hours Min Director 215-78-4616 Usual Residence of Dece 1**X** M 2 □ F 51 Yrs 9/4/1960 MD 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits at with the Maryland Director notified Yes 2 No 28a-f Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number must be 23a Funeral 20877 USA 439 N. Frederick Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4X Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Robert E. Snowden, Sr. Shirley D. Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tran 12628 Grey Eagle Ct., #32, Germantown, MD 20874 Tonesa Snowden/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 2/28/2012 Hanover, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signature, of Funeral Service Licenses M01576 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to ( as a consequence of): Examiner vena Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Vasculitis Cause (Disease or injury that initiated events resulting in death) Last severe attending physician and for use as the burial forms Due to (or as a consequence of) cutaneous the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 L Fetal usea in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 I Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 🔽 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 ho

To the Fune

completely f only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00061386

DHMH 17 Rev 06-2011

Registrar

Medical Center Drive, Pockille, manyland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sonia John MD 31. Date filed (Month, Day, Year)

FEB 28 2012

9901

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SANTIAGO 1-939 J 556 Seb 25 20/2 4b. City, Town, or Location of Death la. Facility Name (If not institution, give street and number) 4c. County of Death Montzonery Subusban NOS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days Months 1⊠M 2□F 79 080-40-7936 Yrs. March 23, 1932 Dominican Republic Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3607 Pear Tree Court, #22 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.White 1 Yes 2 No Specify: Dominican 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Hotel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luis Santiago Altagracia Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number og Ryral Route Number, City or Town, State, Zip Code) Felicia Santiago/Wife 3607 Pear Tree Court, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition March 3, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Park Olney, MD 2012 * 4 Donation 5 Other (Specify) Francis J. Collins Funeral Home Inc. 21. Signature of Paneral Service License 500 University Blvd. W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) C Due to (or as a consequence of) 120 VI Dire to (or as a consequence of) Sacro Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No

Physician /Medical Examiner

sed by the attending physician and detached for use as the burial transitions.

. Pages 1 and 2 should be fill ment of Health and Mental H lant: If Itam 27 is marked oth ury or other traumatic even

ortant: If

Departing Imports any injury i

Physician

/Medical

Examiner

**Funeral** 

Director

"natural", or itama 23a or 28a-f ahow Idical Examinat must be notified at

filed within 72 hours after death

Baltimore, Maryland 21215-0036

7:39p.m

Box 68760

Records, P.O.

of Vitai

Division

Jose

Santiago

or Attanding Physician:

Hospital within 24 hours a To the Funeral (

To the

funeral director

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s after dea...ral Diractor: Aft

Director

Funeral

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Be Completed

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Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

IF FEMALE:

by Physician/Medical

Completed

Be

Certification; To

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

RSPRn

mo

25. Was case referred to medical examiner? examiner? 1. ☐ Yes 2 ☐ No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospital:

28b. Time of Injury 1130 M 28c. Injury at Work? 1 ☐ Yes 2 🚉 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2012

STruck auto Lox 28f. Location (Street and Number or Rural Route Number City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to me cause(s) and manner as stated.

2 Medical Examiner: On the Usis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and my in a stated. icheck only oper 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Rd

KOVMO DMG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 524 Hankey bury IRAN BRECHER, MO, DOME

D00428

Soh 22 20/2

State Registrar 31. Date filed (Month, Day, Year) FEB 28 2012

Silver Spri 32. Registrar's Signature

DHMH 17 Rev 1/2001

		For	State o	f Marylan					and M	1ental Hy	giene	•		
	_1	State Registrar			Cer	tificate	e of D	eath			Reg. No	. 21	112	08040
Physicia	n/	1. Decedent's Name (First, Middle								2. Date of De Month 02		2012	Year	3. Time of Death  2:45 A M
Medic	al .	Ida Adele St				41- 01-	T	14:	of Dooth	02	-		of Death	2:45 A W
Examin	-1	,		ibei)			napo:	Location	or Death				Arund	e1
Funeral		Spa Creek Ce 5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Unde	1 Year	If Under		8. Date of Bi	rth		9. Birthp	ace (State or Foreign
Director		218-26-0320	1 □ M 2 🔀 F	94	Yrs.	Months	Days	Hours	Min.	1477 P	7191	7	Anna	polis,MD
d tow	_	Usual Residence of Decedent  10a. State 10b. County		10c City	y, Town or Lo	cation				_			10	Od. Inside City Limits
arylan a-f sh fied a	Director		rundel		napolis									1 🛣 Yes 2 🗆 No
or 28	ä	10e. Street and Number				10f. Zip	Code				10g. Ci	itizen of \	What Count	ry?
with t	Funeral	11 Shiley Stre	eet			21	401					USA		
death items	핊	11. Marital Status	12. Was Dece	dent Ever in U.S	3. 13. \	Vas Deced	lent of His	spanic Ori	igin? (Spe n. Puerto	cify Yes or No Rican, etc.)	-		e - America	
after c	d b	1 ☐ Never Married 2 ☐ Marr 3 ☐ XWidowed 4 ☐ Divorced	ried 1 🗌 Yes If Yes, Giv	e ² X No	1	1 🗆 Yes							Whit	
ours cal E	Completed	The second secon	Year or Da	ites.	16a. Deced	dent's Usu	al Occupa	ation	_		16b. k	Kind of B	usiness Ind	ustrv
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y a	٦	William T. To			T									
2 shorth and the and traum		19a. Informant's Name/Relationsh Mark Allen Stoo		n						Noute Numb $\mathtt{olis}$ , $\mathtt{M}$			State, Zip C	ode)
1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene.  The mand Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	CREEC DO	20b. F	Place of Dispo	sition (Na	ne of	- 1		Date			- City or To	wn, State
Page 1		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State A1	emetery, crer 1 Ha11	natory or c <b>ows</b> C	ther place eme t	ery [	03/03	3/2012	Dav	idso	nvill	e,MD
permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service L	,		22	2. Name ar	nd Addres	s of Facili	ity		12	Ric	lge1v	Ave
		Vally	are						_			napo	olis,	Ave 1D 21401
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on ea	caused the deat ich line.	h. Do not ent	er the mod	le of dying	g, such as	cardiac o	or respiratory a	irrest,			Approximate Interval Between
Pnysician/	M	Immediate Cause (Final disease or condition	a			m	H	<del>د</del>						Onset and Death
Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):									
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	uence of):									
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	c								_			
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y F.C. BOX 001000 se that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	dical		d											
ertifica ding p	Physician/Me	IF FEMALE:	23c If yes ou	tcome of pregna	ancy							00-L D-	-4- of Jolive	
ath ce	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	Birth 2 Feta	al death 3	Ectopic Other (s		У					ate of delive onth	Day Year
he dex y the a	hysi	1  Yes 2  No 9  Unknown	9 🗆 Unk							-				
that the the ned by a deta	by P	Part II. Other significant condition	ons contributing to	leath but not res	sulting in the I	underlying	cause giv	ren in Parl	t I.	23e. Did	tobacco	use conf	tribute to th	e cause of death?
quires quires en sig										1 🗆	Yes 2		3 Prob	pably 4 🗆 Unknown
e law requires has been sig ge 2 should b	Completed									24a. Wa aut	opsy		prior to coi	osy findings available inpletion of cause of
The It	Con									per 1 🗀 Yes	formed2 2 1 N	No.	death?	2 🗆 No
Vital vsician; s certific director,	Be	25. Was case referred to medical examiner?	Hospital:				26. Pla			k only one)				<del></del>
Physi this c	2	1 Yes 2 No	1 28a. Date	Inpatient 2  of injury	ER/Outpatie		OA Othe	4 <b>C</b> N	Nursing Ho	ome 5 Res				
iding Pl th. After the funera	cate	1 Natural 5 Pendir	ng (Mor	th, Day, Year)	injury	м	work		□No	200. 20001100	now sign	.,		
al or Attendir s after death.	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At he		reet, factor	y, office			28f. Location City or To			per or Rural	Route Number,
Ltal or rs after all Dir			Dulid	ing, etc. (Specin						City or 10	Wii, Olai			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical I	Physician: To the l Examiner: On the ba	sis of examination	n and/or inves	stigation, in	my opinio	on, death o	occurred a	t the time, date	and plac	e, and du	ue to the cau	use(s) and manner stated.
the ithin 2 the other	ž	only one) 3 L Certifying 29b. Signature and tile of certifie	Nurse Practioner:	To the best of m	y knowledge,		urred at the		te and plac		29d D	ate sione	ed (Month )	Day Yearl
F ≥ F ŏ		Dog VA.	In					120	36		2	126	1201	2
		30. Name and address of person	who completed cau	se of death (Iter	n 23a) (Type,	Print)				· ·			1201	- 7
CHIE		J. Das	rone	2148	Or 17	greet	1)~	cve		Lite	^ ^	1/4	2/6	19
Sta Registra		31. Date filed (Month, Day, Year)	2012	tegistrar's Signa	ature		,							•

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vencenza Ann Sparks ebruary Medical Facility Name (if not institution, give street and number) **Examiner** MEDICAL LATA 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) cial Security Number **Funeral** 577-64-6274 M-488388 Director 1 □ M 2 🗶 F 65 2/18/1947 Washington, DC Usual Residence of Deced 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Virginia King George King George 10f. Zip Code 10a. Citizen of What Country? Funeral 5257 Pine Forest Lane Apt. 403 22485 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Finamore Vivian Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Rogers/Daughter 1115 Chesapeake Drive, Stevensville, MD 21666 20a. Method of Disposition
1 □ Burial 2 🛣 Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Kalas Crematory 3/1/2012 Edgewater, MD 21. Signatur of Funeral Service Li 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease or complications shock, or heart failure. Mist only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ UVINAM Medical resulting in death) Examiner COPD Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) physician a Physician/Medical that the death certificate be Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ № 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 KNO Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 0 No 1 Nupatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ail completely filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier velisse Michel, MD 069566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, La Plata, MD Garrett

State Registrar TEB 2 8 2012

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Regist

	1 - For State Registrar		. ,	Certifi	cate of L	Death		Reg.	No. 201	2 08042
	1. Decedent's Name (First, Middle, La	ist)					2.	Date of Death Month	Day Year	3. Time of Death
an o'	Evelyn S	heelor					F	ebruary	21, 2012	3:20 A M
al er	4a. Fecility Name (If not institution, give	ve street and number)		4b	. City, Town, or	Location of E	Death		4c. County of Deat	h
	Heartland of Hyat	tsville Nu	rsing H	me.		Hyatt		le	Prince	George's
		1□M 2DXE	(In yrs. last bii L04		Under 1 Year onths Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, Your 20,	ear) Co	hplace (State or Foreign untry) th Carolina
	Usual Residence of Decedent		10- O'- T	1 4:-						10d Incide City Limite
<u></u>	10a. State 10b. County		10c. City, Tow	n or Locatio	n					10d. Inside City Limits 1 No 2 No
cto	DC					ningtor	n			
Dir.	10e. Street and Number			1	Of. Zip Code				. Citizen of What Co	
ra a	115 U Street NE					2000	_		Jnited Sta	
nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was	Decedent of Hi s, specify Cuba	spanic Origin n, Mexican, F	1? (Specify Puerto Ric	/ Yes or No- an, etc.)	14. Race - Ame Black, Whit	
Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	1 ☐ Yes 2 【XN If Yes, Give Year or Dates:	10	1 🗆 '	Yes 2XNo	Specify:			Specify: Aft	rican
ba	15. Decedent's E		16a	Decedent'	s Usual Occupa	ation		16	b. Kind of Business/	
Set	(Specify only highest gr	rade completed)		(Give kind life. DO N	of work done of NOT use retired	furing most of	f working	11		,
E	Elementary/Secondary (0-12) 6th	College (1-4or 5-	+)	Do	mestic	Worker	c		Self-Em	ployed
O	17. Father's Name (First, Middle, Last	t)				18. Mother's	Name (F	irst, Middle, Ma		
To B	J	John Friday				Emr	ner			unk.
-	19a. Informant's Name/Relationship	(Type. Print)	198	o. Mailing A	ddress (Street a	and Number o	or Rural R	oute Number, C	City or Town, State, 2	Zip Code)
	Curtis Sheelor -	- Grandson	5	02 Mi	11wheel	Stree	et C	apital	Heights,	Md. 20743
	20a. Method of Disposition		20b. Place o	f Disposition	n (Name of ery or other plac	e) Tr -	Date	20	c. Location - City or	Town, State
	1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1		ncoln	FE	ъ. 2 20	- 1	Brantwood	, Maryland
	21. Signature of Funeral Service Lice		<u> </u>	22. Na	ime and Addres	ss of Facility			eral Home	. Inc.
	I goling Tax	Stewers	MÓ0560						ngton, DC	
	23a. Part1. Enter the disease, or con	nplications that caused	the death. Do			-				Approximate Interval Between
	shock, or heart failure. List only immediate Cause (Final	7 one cause on each lin	11mon	10						Onset and Death
	disease or condition resulting in death)	Due to (or as	a consequence	of):						
		CCR	CBRO	NAS	cult	tre 1	4CC	IDEn	07	
le.	Sequentially list conditions, if any, leading to immediate	Due to (or es a	consequence	,		7,0	1			
ig.	cause. Enter Underlying Cause (Disease or injury that initiated events	H 7/9	ERTH	EM.	210re					
Exa	resulting in death) Last	Due to (or as a	a consequence	of):						
ca		d								
edi		3-5								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome   1□Live birth	pf pregnancy 2 □ Fetal death	n 3∏Ect	opic pregnancy	,			23d. Date of de	
Si.	in the past 12 months? 1 ☐ Yes 2 🔀 No	4□Pregnant at 9□Unknown			her (specify)				Month	Day Year
, S	9 ☐ Unknown									
by	Part II. Other significant conditions	contributing to death bu	ut not resulting i	n the under	lying cause give	en in Part i.				the cause of death?
ed							_	1 ∐ Yes	2 No 3 P	robably 4 🗷 Unknown
plet								24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
E O			e de		*			performe	ed? death? ⊠No 1 □ Yes	_
Be C	25. Was case referred to medical examiner?					26. Place o	f Death (C	Check only one)		
<u>o</u>	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie	nt 2 ER/0	utpatient 3	3□ DOA Oth	er: 4 🗷 Nursi	ing Home	5 Residen	ce 6 □Other (Spe	ecify)
	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		Time of Injury	28c. Injur Wor	y et k?	280	d. Describe how	injury occurred	
atic	2 ☐ Accident investigation	on			M 1 □	Yes 2 □ No				
tific	3 ☐ Suicide 6 ☐ Could not be determined		iry - At home, fa c. (Specify)	arm, street,	factory, office		28f	Location (Stre City or Town,	et and Number or R State)	ural Route Number,
Cer										
Medical Certification: To		Physician: To the best of aminer: On the basis of								
ledi	one)	and manner sta	ited.		00-1:					" B V1
2	29b. Signature and title of certifier	AAO			29c. Licens		ì		Date signed (Mon	
	- Chilians	VV			1240	17 /- 1	1	IFE	BRUHR	123,2012
	30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Prin	PAD W	LAN F	01	C +0 -1 =	AA 0 0 - 11	Area 20770
	VICION DITIES	HM +3231	ar's Signature	LUVOR	-1010-K	WH7 6	THE	THELL	MITTIL	Men 70+10
te ar	FEB 2 9 2012	32. Hegistra	a signature	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Marquise Bess Stark Medical 03 2012 5:10 p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Allegany Frostburg Village Nursing Center Frostburg 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 F 11 25 1932 Hours Min. Director 424-40-9024 79 Euell Alabama Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Frostburg 1 ☐ Yes 2 No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 21532 10023 Parkersburg Road NW Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charlev Bess Clennie Smith Bess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10023 Parkersburg Rd NW Frostburg, MD 21532 item 27 John Stark husband Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-12-2012 Eckhart Cemetery Eckhart, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, Frostburg, MD 21532 M00547 60 W. Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final SUPRA NUCLEAR CEREBRAL Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence on): cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Yes 2 No 9 Unknown Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?

Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Records, Division of Vital

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: Al completed filled in by the

State

Medical

1 Natural

2 Accident
3 Suicide

4 Homicide

29a. Certifier

(Check

arı

29b. Signature and title of certifier

5 Pending

tordhu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

6 Could not be

Watsh

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

925 Bishop

32. Registrar's Signature

M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number 2690 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sterner onrad W March Ğ 2012 1:30a Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 5448 Norrisville Road White Hall Harford Social Security Number If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Hours **Director** 166-12-6038 1 **X** M 2 □ F Usual Residence of Decedent 92 Aug. 27, 1919 PA 28a-f show with the Maryland 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Harford White Hall 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be i Funeral 4826 Norrisville Road 21161 U.S.A. items ? permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify. White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Foreman Cable Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Jesse Myers Sterner Maggie Thoman Werner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hendrix/Daughter 5448 Norrisville Rd., White Hall, MD 21161 20a. Method of Disposition 20b. Place of Disposition (Name of St. Paulov or other place) Man ited Methodist Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Pylesville, MD 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Main St., Stewartstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ CHF disease or condition mon 443 Medical resulting in death) Due to (or as a consequence of) **Examiner** ardiomyopath Veer Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine BUDGA Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Xyes 2 No 3 Probably 4 Unknown in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier V3124

DHMH 17 Rev 06-2011

Registrar

Kenwood

Bultimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

Klots2

4 2012

31. Date filed (Month, Day, Year,

5701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY G925 3/14/2012 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2012-2. Date of Death 3. Time of Death Physician/ Month nildred 100 Medical Februcin 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sbero 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F Months (Month, Day, Year) an 20, 1914 214-09-8105 Director 98 Jan_ Maryland Usual Residence of Decedent 28a-f show death with the Maryland at 10a, State 10h County 10c. City, Town or Location Director 10d. Inside City Limits notified 1 X Yes 2 □ No Keedysville Maryland Washington ō 10e. Street and Number 10f, Zip Code an "natural", or items 23a or Medical Examiner must be 10g. Citizen of What Country? Funeral 7 Mount Vernon Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) Ith and Mental H
27 is marked of
traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) 2 George E. Smith Lela Myrtle Doub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st f Health a 27 Judith K. Kerns / daughter Mount Vernon Lane POBox 443 Keedysville, MD 21756 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ò . Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place! Department o Important: If any injury or 4 Donation 5 Other (Specify) 02/29/2012 Fairview Cemetery Keedysville, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Lause (Final Preumon Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ज़ Examir signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 1 Yes 2/19 Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death.

Funeral Director: After this certificate has! autopsy perform Yes 2 No Division of Vital 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 🗌 Yes Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3.X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) manefar 30. Name and address of derso who completed cause of death (Item 23a) (Type, Print) IW-5 11260001

State Registrar 32. Registrar's Signature

				partment of Health and Nertificate of Death		ene . No. 2012	08046
ı			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia Medic		Catherine Lucille Toms		February	24, 2012	5:30 pM
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
•	Funeral		Medstar Montgomery Medical Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday,	01ney  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgom	place (State or Foreign
	Director		579-03-7087 1□M2≅F 92 Yrs.	Months Days Hours Min.	(Month, Day, Ye	ear) Cour	ntry)
	d wo		Usual Residence of Decedent		March 27,		hington, DC
	arylan a-f sh iled a	cto					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Ma or 284	Dire	MD Montgomery Silver	Spring 10f. Zip Code	100	. Citizen of What Cou	
	with t	<b>Funeral Director</b>	3954 Bel Pre Road, Apt. 4	20906	109	USA	,
	death items ier m	Fun		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
36	after of l', or kamir	d by	1 L Never Married 2 L Married 1 L Yes 2 X No	1 ☐ Yes 2 🏝 No Specify:	riidari, etc.)	Black, White, Specify: White	etc. e
ခု	atura cal E	Completed	3 X Widowed 4 Divorced Page 7 Page 7 Page 7 Page 8 Page 7 Page 8 Page 7 Page 8 Page 7 Page 8	edent's Usual Occupation	10		
212	n 72 h an "n Medi	mp	(Specify only highest grade completed) (Gliv  Elementary/Secondary (0-12) College (1-4 or 5+) life.	b. Kind of Business/In	dustry		
7	ygiene /giene ner th	ပိ	12 Secre	tary	Fe	ederal Gov	ernment
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)  John Louis Reidy		e (First, Middle, Maid ne Blasey	den Surname)	
Ž	ould b id Mei mark matic	_		ling Address (Street and Number or Rura			0.41
Σ	12 shoalth an 27 is 27 is r trau	ľ	1	ing Address (Street and Number of Hurs .38 Silver Arrows V			· 1
ore,	1 and of Head Fitem		20a. Method of Disposition 20b. Place of Disp		Date 20	c. Location - City or To	own, State
Ĕ	Page ment ant: If ury or			ematory or other place) Memorial Park	$\begin{bmatrix} n & 2 \\ 2012 \end{bmatrix}$ Re	ockville,	MD
Baitimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		21. Signature of Funeral Service Dicensee	22 Name and Address of Facility Francis J. Collins 00 University Blvd	Funeral 1	Home Inc. ver Spring	, MD 20901
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.				Approximate Interval Between
~!	Physician		Immediate Cause (Final disease or condition				Onset and Death
A STATE OF THE PARTY OF THE PAR	Medical Examiner		Due to (or as a consequence of):				,
		er	Sequentially list conditions, if any leading to immediate b. Acute Myscards  Diagram on sequence of:	14L NYAICHUM			5 Drys
	pg _ 12	amir	Cause, Enter Underlying Cause (Disease or injury	ro Sis			Syenra
	an and rial-	dical Examiner	that initiated events c.  Due to (or as a consequence of):	<del></del>			
00	sate be executed physician and the burial forces	dica	d				
200	ertifica ding p	Physician/Me	IF FEMALE: 23b. Was decedent proposet 23c. If yes, outcome of pregnancy				
XOD DOX	ath ce attend for us	cian	in the past 12 months?	Control of the contr		23d. Date of deliv Month	ery Day Year
0	the de sy the	hysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown				
7. O	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?
as,	quires en sig ould b	Completed by	Hypertension		1 🗆 Yes	2 ☑ No 3 ☐ Pro	bably 4 🗌 Unknown
Records,	law re	nple	1		24a. Was an autopsy	prior to co	psy findings available impletion of cause of
ב	: The l	ပ္ပ			performed	d? death?	2 No
AIL	sician certifi rector	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check	only one)	-	
> 5	r this eral di	e: 10	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	ent 3 DOA 4 Nursing Ho	me 5 Residence	e 6 Other (Specif)	()
	nding ath. r; Afte ie fun	icat	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work?  M 1 1 Yes 2 No	-	njary occurred	
VISION	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura	Route Number,
Ś	vital o urs aff ral Di	aC	<u> </u>				9
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-forcial.	Medical	29a. Certifier  (Check  Check  Check	stigation in my opinion, death occurred at	the time date and of	lace, and due to the ca	use(s) and manner stated.
	To the within To the sompl	Σ	only one) 3 $\square$ Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	e, ueath occurred at the time, date and pla 29c. License number	ice, and due to the ca	ause(s) and manner as: Date signed (Month,	
	- 3 - 30		> yh hann	D18726	Fi	brum 25	
			30. Name and address of person who completed cause of death (Item 23a) (Type,	e, death occurred at the time, date and pla  29c. License number  D18726  Print)  W OLVEY NO 20			
			A SCHATTE GOLD MO 18101 PRINCE PLOTO	ar, Olitas MO 20	832		
	Stat	e	31. Date filed (Month, Day, Year) FEB 2 9 2012	w			
	Registra	r					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Martha February Talley 2012 Ann 5:40  $\mathbf{p}_{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 740 Dennis Avenue Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 578-44-6684 **Director** 1 M 2 X F 77 Nov. 14, 1934 Washington, DC 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2X No MD Montgomery Silver Spring 10e. Street and Numbe ö 10g. Citizen of What Country? must be 23a Funeral 740 Dennis Avenue 20901 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, White Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3[™] Widowed 4 □ Divorced Specify. Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Editor Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ John Francis Myers Martha Margaret Bullick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camille Hoover/Daughter 17101 Spates Hill Road, Poolesville, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖺 Burial 2 🗆 Cremation 3 🗎 Removal from State 28 Feb. 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licen Francis J. Collins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Respiratory Failure disease or condition Medical resulting in death) **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Exami • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2 🗌 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

EB 2 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ira Tauber, MD 10301 Georgia Ave., #304, Silver Spring, MD 20902

2. Registrar's Signature

D18813

Feb. 27, 2012

#### State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ear1 Thompson February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 26825 Dix Street Damascus Montgomery 8. Date of Birth (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours 214-28-2493 **Director P**M 2 □ F 81 Oct.21,1930 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Damascus 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 26825 Dix St. 20872 or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Force 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give than "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 9 Painter and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi f Health and Mental item 27 is marked ൧ William E. Thompson Edna Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy Wetzel, Daughter 26825 Dix Street, Damascus, MD 20872 Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resthaven Mem. Gardens 3/2/2012 Frederick, Maryland of Funeral Service Lifense Signa Molesworth-Williams P.A., Funeral Home any Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specified, Council (First) 26401 Ridge Road, Damascus, Maryland Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 attending IF FEMALE use yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed 24a. Was an has autopsy Hospital or Attending Physician: The this certificate 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 2 🛛 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 24 hours after death. Funeral Director: After this letely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 XNatural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No performed? Yes 2X No 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) February 27, 2012 20850 9707 Medican Center Drive - Suite 300, Rockville, Maryland

2012

14. Race - American Indian.

White

Construction

Black, White, etc.

8:35P M

Birthplace (State or Foreign Country)

Maryland

10d. Inside City Limits

Interval Between Onset and Death

1 Yes 2 No

State

29b. Signature and title of certifier

31. Date filed (Month Day

Manish Agrawal, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

To the P within 2 To the F

Registrar DHMH 17 Rev 06-2011 29c. License number

D62234

Hipolito Colaj Ventura State of Maryland / Department of Health and Mental Hygiene 2012 08049 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day February 27, 2012 Hipolito Colaj Ventura Medical Examiner 0708 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8138 15th Avenue T-2 Langley Park Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** PreigrGuatemala Country Min Months Davs Hours Director 27 8/08/1984 1 X M 2 F NONE Usual Residence of Decedent E 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. Count MD Hyattsville Prince Georges 1 X Yes 2 No or 28a-f shor permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mennal Hygiene.

Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examinar more to a contract of the contract of the contract of the marked of the contract of the marked of the contract of the cont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8138 15th Avenue, Apt. T-2 20783 Guatemala 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 _ White, etc. 2 X No 1 Yes Specify: White 3 Widowed 1

Yes 2

No specify: Guatemala 4 Divorced If Yes, Give Year é 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 JRP MGMT. Landscape 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Andres Colaj Maria Ventura 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rafael Gomez Tix (brother) 8126 15th Ave, Apt T-2, Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 3/20/12 Family Cemetery Guatemala 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service License W.H. Bacon Funeral Home Wanda 3447 14th St, N.W., Washington, DC, 20010 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and **Medical** Death a Acute Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical attending physician : AMENDED 23a, 27, 28a-f, per me,  $g_{925} = 3-19-12 \text{ sm}$ ▼ UNPENDED Records, P.O. Box 68760, The law requires that the death certificate be IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Š 1 Yes 2 No 3 Probably 4 ✔ Unknown pleted 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Sol Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other 1 Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No ٩ 27. Manner of Death After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural subject ingested alcoholic Division 1 Yes 2 X No death. Director: fd 2-27-12 | fd 06:30 am 2 X Accident Beve<u>rages</u> Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8138 15th Ave. Langley Park, MD. 24 hours after 3 Suicide 6 Could not be determined (Specify) Found: Residence the Funeral 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 27, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)
NAR 0 9 2012 32. Registrar's Signature Registrar

OCIME

DHMH 17 Rev 06-2011

Registrar

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ida WEINER 2012 3:20 PM February Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 181-16-7943 Hours (Month, Day, Year) 1 🗆 M 2 🖔 F Director 90 July 31, 1921 Pennsylvania Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director Maryland Prince Georges College Park 1 🗆 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 United States 5968 Westchester Park Drive #202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify. 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Freida (unknown) Harry Goldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5855 Whisper Way, Elkridge, MD 21075 Harold Weiner, Son 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place King David Memorial Garden 02/29/12 5 Other (Specify) Falls Church, VA TarohinskysHebnew Funeral Home 20012 254 Carroll St., NW, Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Renal Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Clostridium dificile Colitis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) B that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the buris Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' death? 2 X N 1 Tes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work 1 X Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Tpletely** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) February 27, 2012 D 45471

State Registrar

Box 68760

P.O.

Records,

of Vital

Division

Yeheyis Negassié, M.D., 1111 Spring St., Suite 214, Silver Spring, MD

20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year,

			For	State of I	Marylan		rtment of H		Mental Hy	giene		00050
			State Registrar			tificate of D	Death	<del>-</del>	Reg. No. 2	112	08052	
	Physicia	n/	1. Decedent's Name (First, Middle,						2. Date of De Month	Day	Year	3. Time of Death
	Medic		Jame 4a. Facility Name (if not institution, c			Villian	1S 4b. City, Town, or	Location of Deat	Februa	ry 23, 2	2012	5:00 A ^M
- 4	Examin	er	8006 Dustin		'/		Freder		'		deric	k
_	Funeral				Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs		th	g. Birthp	place (State or Foreign
	Director		578-40-4033	1 🛣M 2 🗆 F	81	Yrs.	Months Days	Hours Min.	(Month, Da May 13		Mary	**
	how at	Ž	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	ation	<u></u>			1	0d. Inside City Limits
	arylar la-f s ified	Director	Maryland Freder	ick	1	rederio						1 ☐ Yes 2X No
	or 28		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	with s 23a iust b	Funeral	8006 Dustin Dr	ive			21	.701			U.S.	Α.
	death item ner m	Fur	11. Marital Status	12. Was Deceder Armed Forces		6. 13. W	as Decedent of Hi	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ XWidowed 4 ☐ Divorced	If Yes, Give		1	☐ Yes 2 🗓 No	Specify:		Specify		ite
Ö	hours natura ical E	Completed	15. Decedent		s		ent's Usual Occupa			16b. Kind of B	Business/Inc	dustry
215	n 72 e. ian "r Med	dmo	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4 c	or 5+)	life. DC	ind of work done d NOT use retired)	J	rking			n Gas
2	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		12			Cre	dit Mana				t Com	pany
Maryland 21215-0036	e filec ntal H ed ott	To Be	17. Father's Name (First, Middle, La. William Wil						me (First, Middle,		re)	
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<u>ම</u>	f Heal f Heal item		20a. Method of Disposition			lace of Dispos	sition (Name of	1	Date	20c. Location		
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Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau	1	21. Signature of Fineral Service He	ensee Alli	ams	Mc	Name and Address Lesworth 401 Ridg	s of Facility -William	ns P.A.,	Funeral	l Home	e 20872
١			23a. Part 1. Enter the disease, or c	omplications that caus	sed the death						yland	Approximate
	Physician/		shock, or heart failure. List on Immediate Cause (Final disease or condition		nne. Dle My	to 1 om a					- /	Interval Between Onset and Death
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6876	tificat ng ph as th		IF FEMALE:									
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л О	law requires that the nas been signed by the 2 should be detach	by Ph	Part II. Other significant condition	s contributing to deatl	h but not res	ulting in the ur	iderlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to th	ne cause of death?
	uires t n sign uld be								1 🗆	Yes 2 ☐ No	3 🗆 Prol	bably 4 Unknown
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<u> </u>	Physic this c	မ	1 Yes 2 No 27. Manner of Death			ER/Outpatient		4 ☐ Nursing F	lome 5 Resi			)
27. Manner of Death   1										red		
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N N	ral or s after al Dire		4 2 Homode determin	building,	etc. (Specify)	)			City or Tov	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Ex	Physician: To the best aminer: On the basis o Jurse Practitioner: To	of examination	and/or investi	gation, in my opinio	n, death occurred	at the time, date a	and place, and du	ie to the cai	use(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier		Deat Of H	., m.owiedge,	29c. License		s.co, and due to	29d. Date signe		
Þ			Molluss				0000	57691		02-2	3-12	
	12+1		30. Name and address of person when the Gold		f death (Item	23a) (Type, Pr	int) ST.	Freder.	chino	2/70	- (	
	Star Registra	e ar	31. Date filed (Month, Day, Year)	3 2012 32. Redis	strar's Signat	ure A	barker			-		
						0 11						

			1 - State of Maryland / Depar State of Maryland / Certification	tment of Health and N ificate of Death			08053
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Lucille Wood		2. Date of Death February 2	7°, 2012 Year	3. Time of Death 9:05 PM M
	Examir		4a. Facility Name (if not institution, give street and number)  3725 St. Leonard Road	4b. City, Town, or Location of Death St. Leonard		4c. County of Death	
	Funeral Director	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 M 2 1 F 93 Yrs.	If Under 1 Year   If Under 24 Hrs.  Wonths Days Hours Min.	8. Date of Birth  June 5 1918	9. Birth 8 Mary L	place (State or Foreign try)
	aryland a-f show fied at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat  Maryland Calvert St. Leonar			1	0d. Inside City Limits
	vith the Ma 23a or 28a ist be notif	eral Dire	10e. Street and Number 3725 St. Leonard Road	10f. Zip Code 20685	10g.	. Citizen of What Cour	1 ☐ Yes 23€ No
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto l	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: White	etc.
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, Mary	nd 2 should eath and N m 27 is ma		19a. Informant's Name/Relationship (Type, Print)  V. Keith Wood — son 19b. Mailing A	Address (Street and Number or Rura Lomons Island Road S	Route Number, City Leonard I	y or Town, State, Zip ( MD 20685	Code)
imore	Page 1 arment of He tant: If iter		20a. Method of Disposition  1 🔀 Burial 2 $\square$ Cremation 3 $\square$ Removal from State  4 $\square$ Donation 5 $\square$ Other (Specify)	ion (Name of ory or other place) ery March 3, 2012		. Location - City or To ince Frederic	1
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-	Ph_sician/ Medical Examiner	ər	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	he mode of dying, such as cardiac of	respiratory arrest,		Approximate Interval Between Onset and Death
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Records, P.O. Box 68760	he death certifica y the attending p iched for use as t	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 │ Yes 2 ✓ No g │ Unknown  23c. If yes, outcome of pregnancy 1 │ Live Birth 2 │ Fetal death 3 │ E 4 │ Pregnant at time of death 5 │ C	ctopic pregnancy other (specify)		23d. Date of delive Month	ery Day Year
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Division of Vital	hysi this c	To B	25. Was case referred to medical examiner?  1 Yes 2 No 1 Inpatient 2 ER/Outpatient 2  27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1		6 ☐ Other (Specify)	
Division	ital or Atte ins after de al Directo led in by th	al Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	8f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	thin 24 hot the Funer mpleted fil	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occur only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occur only one) 4 Certifying Nurse Practioner: To the best of my knowledge, death occur only one) 5 Certifying Nurse Practioner: To the best of my knowledge, death occur only only only only only only only only	tion, in my opinion, death occurred at the occurred at the time, date and place	he time, date and pla , and due to the caus	ace, and due to the cau se(s) and manner as sta	se(s) and manner stated. ted.
	<b>.</b>		29b. Signature and title of certifier  Makin Goll MD	29c. License number	29d. l	Date signed (Month, E	lay, Year)
JP	w 2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print  MONIO YOUR MONIO PORT  31. Date filed (Month, Day, Year)  32. Registras Signature	MD 200	989		
	Stat Registra	e ir	31. Date filed (Month, Day, Year)  FEB 2.8 2012 Acres 8.	bares			

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Be Completed by Funeral Director

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Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/ Medical

**Examiner** 

Funeral

Director

State Registrar		Ce	rtificat				1ental Hy	_		,	
1. Decedent's Name (First, Middle, Last)	,	llace	rimodi	0 0, 2			2. Date of Dea		20	Year	3. Time of Death
a. Facility Name (if not institution, give s 4011 35th Stre	etreet and number)				Location of nier	Death		40	County	of Death	eorge's
Social Security Number  577-20-3965  Usual Residence of Decedent	7. Ag	e (In yrs. last birthday) 97 Yrs.	If Unde Months	Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da 2/7/1	y, Year)		Coun	h . , DC
Oa. State 10b. County  D.C.		10c. City, Town or L		1						1	0d. Inside City Limits 1   Yes 2 □ No
0e. Street and Number 233 Jefferson	Street 1	1.W.	10f. Zi	Code	11			10g. Ci		Vhat Cour	itry?
Marital Status     Never Married 2 ☐ Married     Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.		Was Decei If Yes, spe 1 Yes	cify Cuba	n, Mexican,	n? (Spe Puerto	cify Yes or No- Rican, etc.)			e - Americ k, White, e <b>Wh</b>	
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Grocer  16b. Kind of Business/Inc.  Give kind of work done during most of working life. DO NOT use retired)  Grocery											
7. Father's Name (First, Middle, Last) Charles C. Wall	ace				18. Mother JoA1	's Name	e (First, Middle, Camar	Maiden 15	Surname	2)	
19a. Informant's Name/Relationship (Type Charles Wallace							l Route Numbe				ode) ad 20712
20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		20b. Place of Disp cemetery, cre Glenwo	matory or o	other plac	e) 2		) 2012			City or To	own, State
21. Signature of Funeral Service License	all a	1					FUNER				E,P.A. ,Md20910
23a. Part 1. Enter the disease, or compl	lications that cause	the death. Do not en	ter the mod	do of duine				want			Approximate
shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each lin	rminal a		ie or dyling	g, such as c	ardiac c	or respiratory ar	rest,			Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e cause on each lin $egin{array}{c} \mathbf{Te} \ & Due \  ext{to} \  ext{(or as} \ & \mathbf{Ch} \ \end{array}$	э.	ge						<u> </u>		Interval Between
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State Registrar 31. Date filed (Month, Day, Year) FEB 2 8 2012

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammed Khalid MD 12001 Ferrara Avenue Wheaton, Md 20906 32. Registrar's Signature

29c. License number

D0043496

29d. Date signed (Month, Day, Year) Feb. 27, 2012

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		For State		State of	Marylan		artment of H <i>tificate of L</i>	Health and N	/lental Hy		0 0	0 0	0055
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Physicia Medic			s D. We	,					02/23		ay Y	'ear	pm M
Examin		4a. Facility Name (if	not institution, g	give street and numbe	r)		4b. City, Town, or	r Location of Death			c. County of		*
<i>A</i>		5740 Bla:					Churc					rundel	
Funeral Director		5. Social Security Nu 578-50-4(		5. Sex 7.	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth 2/193	8 1	9. Birthplace (S Washing	
d tr	_	Usual Residence of 10a. State	Decedent 10b. County		10c Cit	v. Town or Lo	nation					10-l Inci	de City Limits
larylar 8a-fsh ified	ecto	MD .	Anne A	runde1		nurcht							Yes 2 X No
the M	Ϊ́	10e. Street and Num	nber				10f. Zip Code			10g. C	itizen of Wh	at Country?	
h with ns 23e nust k	Funeral Director	5740 Bla	ine Roa	d			20733			USA			
r deat or iten iiner r	by Fu	<ul><li>11. Marital Status</li><li>1  Never Marri</li></ul>	XX.	12. Was Decede Armed Force	s?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	)		American India White, etc.	ın,
s afte ral", c Exam		3 Widowed		1 Yes 2 If Yes, Give Year or Dates		1	I ☐ Yes 2 🌠 No	Specify:			Specify:	White	
2 hour "natu edical	Completed	(Spec	15. Decedent	's Education t grade completed)		16a. Deced	dent's Usual Occup	eation	ina	16b. l	Kind of Busi	ness Industry	
thin 7; ane. <b>than</b> he Me	m o	Elementary/Seco		College (1-4	or 5+)	life. D	O NOT use retired) Mailer	during most of work	,,,,g	Ne	wspap	er	
led wi Hygie other ent, ti	Be	17. Father's Name (F	First, Middle, Las	st)				18. Mother's Nam	e (First, Middle				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	Samue1	Weimer						Myers		,		
shou h and 7 is m rraums		19a. Informant's Na  Janet We:						and Number or Rura				e, Zip Code)	
and 2 Healtl		20a. Method of Disp		pouse	20h E		sition (Name of	load Chur		_		ity or Town, Sta	to
age 1 ent of nt: If ii		1 Burial 2 ☐ 4 ☐ Donation	☐ Cremation 3	Removal from Sta	ate Res	emetery, cren stlawn	natory or other place Cemetery	^(ce) 02/27	Date 7 / 12		alle,	-	te
permit. F Departm Importal any injui		21. Signature of Fur				22	Name and Address	on of Equility		12	Dida	0177 4770	
8 <b>2 E 6</b>	Ц	Oat	141					uneral Ho			napol	is,MD 2	1401
Physician/ Medical		23a. Part 1. Enter the shock, or hear Immediate Cause (Fidisease or condition resulting in death)	t failure. List onl Final	omplications that cau ly one cause on each	sed the deat line. as a consequ		Long	g, such as cardiac o		arrest,		Interva	ximate al Between and Death
Examiner	_	Sequentially list cor	nditions	b. ——		,							
sit sit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying	Due to (or	as a consequ	uence of):							
		that initiated events resulting in death) L		c. Due to (or a	as a consequ	uence of):							
cate be e physiciar the buria	ical			d									
tificate Ing phys	Med	IF FEMALE:	-										
Attending Physician: The law requires that the death certificate be redath.  ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the bi	Physician/Medical	23b. Was decedent   in the past 12 n 1 Yes 2 Section 2 Unknown	nonths?	23c. If yes, outcor 1 ☐ Live Birl 4 ☐ Pregnar 9 ☐ Unknow	th 2 D Feta it at time of c	al death 3 🗌	Ectopic pregnanc Other (specify)	ру		:	23d. Date of Month		Year
es that the des signed by the a be detached t	by Ph	Part II. Other signifi		s contributing to deat		ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribu	ute to the cause	of death?
requires / requires signal been signal should be			ev	nphyseu	19				12	Yes 2	2 □ No 3	☐ Probably	4 🗌 Unknown
aw rec as bee 2 sho	Completed								24a. Was	s an opsy	24b. Wei	re autopsy find or to completion	ngs available
The land	S									formed?	dea	ath? ☐ Yes 2 ☐ N	
sician: The law certificate has birector, page 2 s	<u>m</u>	25. Was case referre examiner?	_	Hospital:			Othe	ace of Death (Check	k only one)				
Phys rr this eral di	으	1 Yes 2 2		28a. Date of i	njury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injun	4 ☐ Nursing Ho	me 5 Res 28d. Describe		6 Other (	Specify)	
ath. r: After he funera	icat	1 Natural 2 Accident	5 Pending Investiga	tion	Day, Year)	injury	work				,, 00001100		
or Atter de irecto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ad 28e. Place of	Injury - At ho etc. (Specify		eet, factory, office		28f. Location City or To	(Street ar	nd Number o	or Rural Route I	Jumber,
pital cours a eral D eral D filled i		29a. Certifier 1	Contifuing D	Physician: To the best	of my knowl	lodge deeth s	aggured at the time	dete and place on					
n 24 h n 24 h ie Fun	Medical	(Check 2	Medical Exa	aminer: On the basis of lurse Practioner: To t	of examination	n and/or invest	igation, in my opinic	on, death occurred at	the time, date	and place	e, and due to	the cause(s) ar	d manner stated
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completed filled in by the fun		29b. Signature and		` 0			29c. License	number		29d. Da	ate signed (A	Aonth. Dav. Yea	r)
		<b>&gt;</b> \( \nabla \).	All		W.C	<b>/,</b>	$\perp \nu$	4838			2/24	1/2012	
014				Clonicu,		23a) (Type, P	03 Medi	9838 cal Pavk	way,	Anı	napol	lis, Mo	1. 21401
Stat Registra	e Ir	31. Date filed (Month	EB 2 8	2012 32. Figit	strar's Signat	d.	all						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ A RBO LCHARD 8:15 MPN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 121-26-4152 Director 1 🛛 M 2 🗆 F 10/21/1932 79 New York Usual Residence of Decedent or 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ritems 23a or 28a-f stiner must be notified MD 1 Yes 2 XNo Anne Arundel Churchton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5529 Exeter Street 20733 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married ō þ Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Hygiene. other than "natural", Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Photo Engraver Newspaper Ith and Mental Hygie

27 is marked other

traumatic event, tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ည Burton Warboy Coralynn Gugenheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Villa Warboy Spouse 5529 Exeter Street Churchton, MD 20733 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department or Important: If any injury or 02/25/2012 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A.Annapolis,MD 21401 mthia 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner EARS Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-transit The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician. should be detached for العجم عليه المناخ by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3r Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes မ 2 - No Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Director: After Natural 5 Pending work?
1 Yes 2 No M Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 232012

State Registrar

DHMH 17 Rev 06-2011

Box 68760

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 2 8 2012

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	_	State Registrar			Cer	tificate	of D	eath		Reg. N	10. 201	2	1005
Physicia Medic		1. Decedent's Name (First, Middle, Las Bettie Sue Wynn	•						2. Date of De Month 2-25-		ay Year 2		ime of Death  Control A M
Examin	er	4a. Facility Name (if not institution, give 14139 Castle Blv				1		Location of Death	1	- 1	c. County of De		
Funeral Director		5. Social Security Number 6. Se 227-42-9721	2 X 7. Age		st birthday) Yrs.	If Under		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th 1 Year 1 9 2	9 g. E	lirthplace ( country)	State or Foreign
nd <b>how</b>	٦	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	cation						10d. In	side City Limits
Maryla 28a-f s notified	irect	MD Montgom	ery	Sil	ver Sp	<del>,                                    </del>						12	Yes 2 No
with the	Funeral Director	10e. Street and Number 14139 Castle Blvd	•			10f. Zip (				10g. 0	Citizen of What (	Country?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🏅 Divorced	12. Was Decedent Ev Armed Forces ? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates,	ver in U.S. No	If	Vas Decede Yes, specif	fy Cuban	panic Origin? (Sp., Mexican, Puert Specify:	pecify Yes or No- Pican, etc.)		14. Race - An Black, Wh Specify:		
72 hour n "natu fedical	Completed	15. Decedent's Ec (Specify only highest gra			16a. Deced	ent's Usual and of work NOT use	done du	tion uring most of wor	king	16b.	Kind of Busines	s Industry	
within ygiene.		Elementary/Seconday (0-12)	College (1-4 or 5-	+)				Secret	ary ————	(	Governme	nt	
be filec ental H rked otl	To Be	17. Father's Name (First, Middle, Last)  Ulysses Boone						18. Mother's Nar Mary Lo					
2 should th and M 7 is ma traumat		19a. Informant's Name/Relationship (Ty	/pe, Print)				Street ar	nd Number or Ru	ral Route Numbe	er, City	or Town, State, 2	Zip Code)	
of Heall of Heall or other		Percy Wynn/Son  20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	20b. Pla	ace of Dispos metery, crem	sition (Name	e of	· !	Date		Location - City	or Town, S	tate
nit. Page artment ortant: injury o		4 Donation 5 Other (Specification 21. Signature of Funeral Service Licens			ingtor	n Nati	onal				itland,		_
Dep Imp any onc		Vatrab	well (	0108	5 5	5538 M	lar1	oro Pik	e, Fore	stvi	11e, MI	207	47
Physician/ ⊢ Medical		23a. Part 1 Enter the disease, or compensors, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Pa	ncre	atic (		,	, such as cardiac	or respiratory ar	rest,		Inter	oximate val Between ot and Death
Examiner		Sequentially list conditions,	Due to (or as a	conseque	ence ot):								
rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	conseque	ence of):								
ath certificate be executed attending physician and for use as the burial-transit	cal Ex	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):								
ificate big physical	Medic	IF FEMALE:	d							1			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the		23b. Was decedent pregnant in the past 12 months?  1 Yes 2X No	23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal	death 3	Ectopic pr Other (spe					23d. Date of o	elivery Day	Year
requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions co	ontributing to death bu	it not resu	Iting in the u	nderlying ca	ause give	en in Part I.			use contribute		
The law req ate has bee page 2 sho	Completed								24a. Was auto perfo	psy ormed?	prior to death?	completion	dings available on of cause of
sician: The certificate I irector, pagi	8	25. Was case referred to medical examiner?  1 ☒ Yes 2 ☐ No	Hospital:				Other	ce of Death (Che	ck only one)				
ding Phys th. After this of funeral dir	ate: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of injury (Month, Day,	y 2	R/Outpatien 28b. Time of injury		c. Injury work?	_4 □ Nursing F	ome 5 🔼 Resi			ecify)	
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			ne, farm, stre	M et, factory,		′es 2□No	28f. Location ( City or Tov		nd Number or Fi e)	ural Route	Number,
Hospital 24 hours Funeral I ted filled	Medical (	(Check 2 Medical Examin	sician: To the best of mer: On the basis of exa	amination a	and/or investi	igation, in m	y opinion	, death occurred	at the time, date a	and plac	e, and due to the	e cause(s) a	and manner stated
<b>To the</b> I within 2 <b>To the</b> I comple		only one) 3 L Certifying Nurs  29b. Signature and title of certifier	e Practioner: To the b	est of my l	knowledge, d	eath occurre	ed at the License	time, date and pla number	ace, and due to th	e cause	(s) and manner a ate signed (Mor	s stated.	
5		Jocelyne					374	18		2	1271	201	2
13		30. Name and address of person who c  Jocelyne Kouatchou					1 Rd	, Belts	ville, M	ID 2	0705		
Stat Registra	_	31. Date filed (Month, Day, Year) FEB 2 9 2012	→ 32. Registrar	's Signatu									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 118058 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 0'Mara Wilson Josephine February 5:25p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Carriage Hill If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Hours Days 213-03-2766 Director 1 □ M 2🛣 F December 15,1908 Maryland 103 Usual Residence of Deced 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Bethesda 1 🏿 Yes 2 □ No MDMontgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or Funeral 6904 River Road 20817 USA items 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify Specify: White "natural", Completed 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) the Me than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Hitem 27 is marked of other traumatic eve ဂ္ John Thomas O'Hara Josephine Larkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Line Bost Lane Swansboro, NC 28584 Francis E. Wilson Jr./Son item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington Nat. Cemetery 20c. Location - City or Town, State o = 10 1 🛭 Burial 2 🗆 Cremation 3 🗀 Removal from State Department of Important: If any injury or once. 2/29/12 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Frin Service Icensee 22. Name and Address of Facility M01373 Murphy FH 4510 Wilson Blvd. Arl., VA 22203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Phylician CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical  $\mbox{or Attending Physician}.$  The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 PNo funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: è Other: 1 🗌 Yes 2 **2** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

RUONB

2000

2/22/12

DHMH 17 Rev 06-2011

Registrar

State

5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ March 12^{ay} 2012 Ralph A. Austin 11:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, Country)Virginia Months Hours Feb 6, 1922 1 🌠 M 2 🗆 F Director 229-24-0688 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland **Funeral Director** must be notified Bel Air 28a-f Maryland Harford 1 Yes 2 No 10e. Street and Number ö 10g. Citizen of What Country? 21014 United States 2210 Creswell Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or, þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give 1 Yes 2 No Specify: "natural". 3 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Wind Tunnel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Geneva Hartsock Charles S. Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2039 Franklin Church Rd., Darlington, MD 21034 Beverly Billings / Niece permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 03/14/2012 | Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Internal Between On et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 5-quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine attending physician and for use as the burial-tran that initiated events resulting in death) Last quence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tor, After this certificate has been signed the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner?

1 \( \sum \) Yes 2 \( \sum \) No 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year). 28b. Time of Certificate: 28d. Describe how injury occurred or Attending iniury 5 Pending within 24 hours after death.

To the Funeral Director; A completed filled in by the fu Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Frantioner To the basis of my knowledge doesn't council at the time. Sate and place are controlled to the cause(s) and manner as filtered. (Check the 0 ddress of person who completed cause of death (Item 23a) (Type, Print) 1716 Harford Road, Suite 105, Fallston MD 21047

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_	For State Registrar	Otate C	n iviai yiai i	•	tificate of L		u wentai n	Reg. No. 🤈 [	112	08061
Physicia		1. Decedent's Name (First, Middle Maryann Allen	e, Last)					2. Date of D Month March	Death 12, Day 201	2 Year	3. Time of Death 7:13 P M
Medic Examin	_	4a. Facility Name (if not institution 6585 Colebrook		nber)		4b. City, Town, or Middleto			4c. Count	y of Death erick	
Funeral Director		5. Social Security Number 220–36–6807	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24	Vin. (Month, E	irth Day, Year)	9. Birthp	lace (State or Foreign try)
		Usual Residence of Decedent  10a. State  10b. County	1 □ M 2 🛛 F		Yrs. y, Town or Loc			Jun 1	9, 1940	Mary	
Marylan 28a-f sh otified a	Director	MD Freder			dletow						0d. Inside City Limits 1 ☐ Yes 2X No
with the s 23a or 2 ust be no	Funeral Di	10e. Street and Number 6585 Colebrook	Lane			10f. Zip Code 21769			10g. Citizen of USA	What Coun	try?
2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	S	11. Marital Status  1 □ Never Married 2 □ Mar  3 ☒ Widowed 4 □ Divorced	Armed Fo	re		Vas Decedent of H Yes, specify Cuba		? (Specify Yes or No uerto Rican, etc.)	14. Ra Bla Specif	ce - Americ ack, White, e	etc.
thin 72 hoursine. than "natur ne Medical I	Completed		nt's Education est grade completed College (1		(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during most of	working	16b. Kind of E	Business/Ind	dustry
filed wil	Be	Retail e, Maiden Surnan		2							
2 should be filed within 7 and Mental Hygiene. 77 is marked other than traumatic event, the M	욘	Harold Elliott,  19a. Informant's Name/Relations			19h Mailin	a Address (Street		es Mary H		State 7in (	ode)
and 2 sh Health ar Im 27 is her trau	Ì	Michael Allen,			6585	Colebrool		Middleto	wn, MD 2	1769	·
permit. Page 1 and 2 st Department of Health a Important: If Item 27 is any injury or other trai		20a. Method of Disposition  1 ☐ Burial 2 【***Cremation 4 ☐ Donation 5 ☐ Other (\$		State C	emetery, crem	sition (Name of latory or other place rney Crei	natory	Date 03/14/20	20c. Location	,	·
permit Depart Impor any in	İ	21. Signature of Funeral Service I	Le de	MO1	22 <b>G</b> O: 251 <b>Be</b> Y	Name and Address ing Home verly L	ss of Facility Cremat Heckro	ion Serv	ice P.O	. Box	784 MD 21029
Physician/ Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	caused the deat ach line.	h. Do not ente	r the mode of dyin	g, such as car	diac or espiratory	arrest, lea		Approximate Interval Between Onset and Death
Examiner			Due to	or as a consequ	uence of):	***	U	U			
nted d ansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	denice oi).						
	Aedical Ex	that initiated events resulting in death) Last	Due to	(or as a consequ	uence of):						
ൂ തര ⊒	л/Мес	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	incy				224 D	ate of delive	No.
the death c by the atter ached for u	Physician/N	in the past 12 months?  1 Yes 2 No 9 Unknown		nant at time of		Ectopic pregnand Other (specify)	у 			onth	Day Year
tha gned	by	Part II. Other significant conditi	ons contributing to d	leath but not res	sulting in the u	nderlying cause gi	ven in Part I.				e cause of death?
The ate	Completed							nei	s an 24b. copsy formed s 2 No	Were autor prior to col death? 1 \( \subseteq Yes	osy findings available mpletion of cause of 2 No
Physician: The this certificate eral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	Inpatient 2 🗆	ER/Outnatien	Oth	er.	Check only one)	sidence 6 🗆 Ot	hor (Spacific	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director, After this certific completely filled in by the funeral director,	Certificate: T		28a. Date (Mon igation		28b. Time of injury	28c. Injur work	y at	28d. Describe	e how injury occur		
Hospital or Attending 24 hours after death. Funeral Director: After etely filled in by the fune		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 28e. Place	of Injury - At hong, etc. (Specify	ome, farm, stre	et, factory, office			(Street and Numi own, State)	ber or Rural	Route Number,
the Hospital thin 24 hours : the Funeral ( mpletely filled	Medical	(Check 2 Medical I only one) 3 Cortifying	Nurse Practitione	sis of examination	n and/or invest	igation, in my opinio	on, death occur	rred at the time, date	e and place, and d	ue to the cau	use(s) and manner stated.
To the within 2 To the comple		29b. Signature and title of contifie	1	y 3	ND	29c. License DS	839	/	29d. Date signe 3 - /	3-1	2
		30. Name and address of person	completed cause	se of death (Item	23a) (Type, P 2. 8D	1 Toll	Hore	se Ar	ve, F	reck	rich MI
Stat Registra		31. Date filed (Month, Day, Year)  MAR 1 5 2		legistrar's Signa	bar	V			,		21701

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 Registrar DHMH 17 Rev 06-2011

ORIGINAL

		101	f Maryland / Depa	artment of H	lealth and N	/lental Hygi	ene		
		1 = State Registrar	Cer	tificate of D	eath	Re	g. No. 2	012 08062	2
Physic		1. Decedent's Name (First, Middle, Last)	nova L. f	Hikens		2. Date of Death Month		Year 7012 7 17 17 17 M	
Exam	dical niner	4a. Facility Name (if not institution, give street and num		4b. City, Town, or	Location of Death	, , , , , , ,		ty of Death	٦
/		Seasons Hospice at Northw	est Hospital		llstown		Ва	ltimore	
Funera Directo		236-66-1815 ¹₹M2□F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 15,	^(ear) 1940	9. Birthplace (State or Foreign Country) West Virginia	
yland f show ed at	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	1
e Mar 28a- notifie	Director	MD Baltimore	Brookly					1 ☐ Yes 2 🔀 No	_
vith the 23a or st be r	in i	10e. Street and Number 5509 Patrick Henry Dr.		10f. Zip Code 21225		11	Og. Citizen of USA	What Co <i>u</i> ntry?	
eath v tems er mu	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S. 13.	Vas Decedent of Hi	spanic Origin? (Spanic Origin?	ecify Yes or No-		ce - American Indian,	$\dashv$
ZIZI3-0030 within 72 hours after d giene. er than "natural", or i , the Medical Examin	2	1 Never Married 2 Married 1 Yes	9	f Yes, specify C <i>u</i> bar 1 $\square$ Yes 2 $X$ No		Hican, etc.)	Bla Specify	ack, White, etc. _{Ty:} white	
2 hour	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation Jurina most of work	ina	6b. Kind of E	Business/Industry unk	٦
ILLI Ithin 7: ene. than he Me	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+) life. D	O NOT use retired) laborer	amig most or tron	9			
iled w Hygin other	B	17. Father's Name (First, Middle, Last)		Idborer	18. Mother's Nam	e (First, Middle, M	aiden Surnam	ne)	┨
yiand Ild be filed Mental Hy larked oth	P	Burnird Lee Aikens			Virgie	Patricia	a Pain	ter	
ar a		19a. Informant's Name/Relationship (Type, Print) Sarah Saigi - sister	19b. Mailii 13	ng Address (Street a 02 Forest	nd Number or Run Hill Av	al Route Number, 0 e; Baltin	City or Town, nore, 1	State, Zip Code) MD 21230	1
baltimore, IVI; permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from  4  Donation 5  Other (Specify)	State 20b. Place of Dispo cemetery, crer	osition (Name of matory or other plac	e)	Date 2	20c. Location	- City or Town, State	
permit. Departinimporta	once	21. Signature of un mel Service Licent e Ronal of Swales,	22	2. Name and Addres			-	rd MD 21201	
		23a. Part 1. Enter the disease, or complications that c shock or heart failure. List only one cause on ea						Approximate Interval Between	
Physicia	_	Immediate Cause (Final disease or condition resulting in death)		COPP	_			Onset and Death	
Medic Examine		Due to (	or as a consequence of):					/	
	je je	Sequentially list conditions, if any, leading to immediate Due to (	or as a consequence of):						٦
cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						- 1	_
ate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (	or as a consequence of):						
icate by physical as the k	edic	d							
DIVISION OF VITAL RECORDS, P.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		Ectopic pregnanc Other (specify)	у			Date of delivery Nonth Day Year	
es that the signed by	ھ ا	Fait ii. Other significant conditions contributing to di	eath but not resulting in the u	underlying cause giv	ren in Part I.			ntribute to the cause of death?  3 Probably 4 Unknown	
ecords, e law requires e has been sig ge 2 should b	Completed					24a. Was an		. Were autopsy findings available	$\dashv$
fec he law te has	l m					autops perform 1 \sum Yes 2	red?	prior to completion of cause of death?  1  Yes 2 No	
VICAL K ysician: Th is certificate director, pa	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Chec		INO	infeticat	
hysic hysic this ce	ြု	1 ☐ Yes 2 🔼 No	Inpatient 2 ER/Outpatie		4 ☐ Nursing H	ome 5 🗆 Reside	nce 6 12 Otl	her (Specify) Los Ne	
n OT ding Pl h. After th funera	Certificate:	27. Manner of Death  1 Natural 5 Pending  28a. Date (Mont	of injury th, Day, Year) 28b. Time o injury	work		28d. Describe how	v injury occur	rred	
Atten r deat ector:	Įį.	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place	of Injury - At home, farm, str		ies 2 🗆 ivo	28f. Location (Str	eet and Numi	ber or Rural Route Number,	$\dashv$
DIVISION  vital or Attendir  urs after death.  ral Director: Af  illed in by the fu			ng, etc. (Specify)			City or Town,			_
the Hosp nin 24 ho the Fune apletely fi	Medical		is of examination and/or inves	stigation, in my opinic e, death occurred at t	n, death occurred a he time, date and pl	it the time, date and	place, and d	lue to the cause(s) and manner state	∌d.
To with		29b. Signature and title of certifier		29c. License	37573	29	March	ed (Month, Day, Year)	
		30. Name and address of person who completed aus	225 5. HA	Di - The	Hima	MO 7	1209		
	tate	31. Date filed (Month, Day, Year) 32 R	egistrar's Signature	41					
Regis	strar	MAR 1 5 2012 L	was B. Aga	ure -					$\Box$

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2ď12 3:30 РМ Mary Margaret Abendshein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** May 3, Hours Min. Maryland 215-50-4755 65 Director 1 □ M 2 🛣 F Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 No MD Montgomery Gaithersburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò must be 20877 118 Duvall Ln #204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) MKRUH 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or ite Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " 4, the M Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene
7 is marked other th fund raising 12 ABONDSHEIM Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Page 1 and 2 should be ment of Health and Ments Adelaide Elizabeth Keys Wilbert Edward Logsdon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Duvall Ln #204; Gaithersburg, MD 20877 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Harry M. Abendshein - husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) von s 22. Name and Address of Facility State Anatomy Board ARV 655 W. Baltimore St; Baltimore, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ regarator disease or condition Medical resulting in death) Due to or as a consequence of) **Examiner** Small cel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation s after deat Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

within 24 hor To the Fune completely f

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5

2 2

State Registrar only one

29b. Signature and title of certifie

^{Year)} 2012

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sireesha Jalli, MD 9901 Medical Center Drix, fockille, Maryland 20850

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D00 680 80

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State		State of I	Marylan		rtment o tificate o		and N	lental Hy	•	00	10	വ	nsl.
			Registrar  1. Decedent's Name	(First, Middle, Last	)		Cert	incate 0	Deaur		2. Date of De	Reg. No	0	16	3. Time	of Death
	Physicia		Margar		therine	Δ	lspaug	h			Month March	1.	ay 2	Year <b>012</b>		00 A M
	Medic Examin		4a. Facility Name (if r				Johns	4b. City, Towr	n, or Location	of Death			c. County o			
ممدرو	<u> </u>			Champion					msvil	le, er 24 Hrs.			Fr	eder:		
	Funeral Director		5. Social Security Nu 394–18–39 Usual Residence of	194	M 2 🔀 F	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, Da Apr. 6	th y, Year) , 19	19	Counti	ace (State y) CONS	or Foreign in
	show dat	ro	10a. State	10b. County	1	10c. City	, Town or Loc	ation						10	d. Inside	City Limits
	Mary 28a-f otifie	Director	Maryland	Frede	erick			Ijamsv	ville						1 🗆 Y	es 2 🔀 No
	th the 3a or t be n	al D	10e. Street and Num					10f. Zip Cod		75.4		10g. C	itizen of W		ry?	
	ath wi	Funeral	10265 Cr.	ampion Co	12. Was Deceder	nt Ever in U.S	113. W	as Decedent o		754	ecify Yes or No-	1	U.S		n Indian	
Maryland 21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	1 Never Marrie		Armed Forces  1 Yes 2  If Yes, Give  Year or Dates	s? ₩ No	1f	Yes, specify C	uban, Mexica	an, Puerto	Rican, etc.)	i		, White, e	tc.	1
5-0	"natur	Completed	Spec	15. Decedent's Ed ify only highest grad				ent's Usual Oci ind of work do		st of work	ina	16b. k	Kind of Bus	siness/Ind	ustry	
121	thin 72 sne. than '	om	Elementary/Secon	ndary (0-12)	College (1-4 o	or 5+)	life. DC	NOT use retir	ed)	or or work	''g			hom	_	
d 2	iled within I Hygiene. other tha	Be C	17. Father's Name (F	2   irst. Middle. Last)	1			homema		her's Nam	e (First, Middle,	Maiden		home	=	<u>-</u>
lan	ould be filed d Mental Hy marked oth matic event	10	John Cav						10.1110		garet M		,			
lary	2 should be filed within 72 hour th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical	į.	19a. Informant's Nar		e, Print)		19b. Mailing	g Address (Stre	eet and Numl		l Route Numbe			ate, Zip C	ode)	==-/
	= 4		Michael J		gh/son			5 Champ		t.	Ijamsv		_			
ore	0		20a. Method of Dispo	osition Cremation 3 🗌	Removal from Sta	ate C	emetery, crem	sition (Name of atory or other p	olace)		Date		ocation - 0	-		
Baltimore,	permit. Page Department o Important: If any injury or once,			5 Other (Specify		All		y Crema			/2012		kesvi		MD	
Ba	permit. Departr Import any inji		21. Signal/re // un	une C	· Xax	Yes	<u> </u>	1802_Li	iberty	Rd.	tzler E Liber	tyto			1762	
Ш			23a. Part 1. Enter the shock, or heart Immediate Cause (F	failure. List only on	and the second of the	Photo a					or respiratory ar	rest,			Approxim Interval B Onset and	etween
	Physicia Medical		disease or condition resulting in death)			consequ		at t	احد (ن)	e				-		
	Examiner				Duc to (01)	ooriooqu	-									
Į,	+	iner	Sequentially list con if any, leading to import the course. Enter United	mediate	Due to (or a	as a consequ	ience of):									
	scuted and transi	Examiner	Cause (Disease or in that initiated events	njury	C. Due to for	as a consequ	ioneo ofi:									
	death certificate be executed re attending physician and ed for use as the burial-transit	calE	resulting in death) L	asi L		as a consequ	ience on.									
292	icate l	ledical			d									+-		
Box 68	eath certifica e attending ph d for use as t	an/N	IF FEMALE: 23b. Was decedent p	regnant	3c. If yes, outcom			Ectopic pregr	ancy				23d. Date	of delive	y	
	is that the death certi igned by the attendin be detached for use	Physician/M	in the past 12 m 1 Pes 2 2 9 Unknown	No	4 Pregnan 9 Unknow	nt at time of d		Other (specify					Mon	th	Day	Year
P.O.	Attending Physician: The law requires that the de ra death.  ector: After this certificate has been signed by the by the funeral director, page 2 should be detached		Part II. Other signific				ulting in the ur	nderlying cause	given in Par	t I.	23e. Did t	obacco	use contrib	oute to the	e cause of	death?
	v requires that been signed to should be det	d by	CAR	10 mjeg.	atley						1 🗆	Yes 2	HNO :	3 🗌 Prob	ably 4	Unknown
ord	v requ	Completed	Al	rial f.	Lalla	tion					24a. Was		24b. W	ere autop	sy finding	s available f cause of
3ec	ician: The law certificate has rector, page 2	mo										psy ormed? 2 4	de	eath?		cause of
E	ysician: 1 s certifica director, p	Be C	25. Was case referre examiner?						. Place of De	ath (Checi						
Š	Physic this or	은	1 Yes 2 27. Manner of Death	No I	lospital: 1  lnp 28a. Date of i		ER/Outpatient	3 🗌 DOA			me 5 🔀 Resi					
D 0	ding F h. After funer	cate	1 Natural	5 Pending		njury Day, Year)	28b. Time of injury	V	njury at vork? □ Yes 2 [	- 1	28d. Describe I	now injui	ry occurred	1		
Division of Vital Records,	I or Attendii after death. Director: Al	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place of					110	28f. Location (	Street ar	nd Number	or Rural i	Route Nur	mber,
Div	tal or rs afte al Dire		T E TIOMINIA		building,	etc. (Specify,	)				City or Tov	vn, State	e) 			
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral	Medical	(Check 2	Certifying Physi Medical Examin	er: On the basis of	of examination	and/or investi	gation, in my or	oinion, death	occurred a	the time, date	and place	e, and due	to the cau	se(s) and r	nanner stated.
	To the within to the complex c	2	29b. Signature and t		>				ense number	117			ate signed			
			1	16		MD			546	16		3/1	13/0	2012	7	
			30. Name and addre	ss of person who co	propleted cause of	of death (Item	23a) (Type, Pi	rint)	201		G1					
	Sta	10	31. Date filed (Month	, Day, Year)	neet F	strar's Signa	ure Z	W. S	,01		Shawn .	A. E	Buki			
	Registra		31. Date filed (Month	R 1 5 2017	Cleren	NB	gode									

DHMH 17 Rev 06-2011

12-02109 Pamela M Allen

amela M Allen		I- For State	ate of Maryla		artment of rtificate of		and	Mental	l Hygie		eg. No.	201	2	0806		
Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)							te of Dea	ith	Vane	3. Tin	ne of Death		
ledical Exami		and the second s								onth arch 13	, 2012	Year	11	54 hrs		
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea										County of Dearederick	ith			
		Frederick Memorial H		Frederick				rs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State								
Funeral		5. Social Security Number	6. Sex	ast birthday)	If Under 1 Months					16 1962		Foreign				
Director		215-84-1341 _{1 M 2 XF} 50 Yr									Feb 16 1962 Country) DE					
any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Locati	on							10d. I	nside City Limits		
<b>*</b> .11			derick		derick								1 [	Yes 2 X No		
	뱛	10e. Street and Number 10f. Zip Coo							Code 10g. Citizen of What Country?							
e Mai or 28	Director	6133 Fieldc		21701				USA								
vith th	— L	11. Marital Status	.S. 13. Wa	Was Decedent of Hispanic Origin? ( Sp				pecify Yes or No- 14. Race - American Indian, B				dian, Black,				
item	nue	1 Never Married 2 M	If Y	If Yes, specify Cuban, Mexican, Puerto					o Rican, etc.) White, etc.							
fter d	ш	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1					Yes 2 X No specify:					Specify: white				
ours a atura camir	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation ( during most of working life. DO												у		
72 ho	ete	Elementary/Secondary (0-12)	College (	(1-4 or 5+)			-	00 1401 450	o rourou,		140	mesti	-			
within ene.	Completed	12 homemaker						I (Fise	ame (First, Middle, Maiden Surname)							
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. ft: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)  John Theodore Farinholt  18. Mother's Nam Mary (								Cecelia Wurtzer						
	o Be	19a. Informant's Name/Relations			19b. Mailing	Address (	Street a	and Number	r or Rural	Route Nu	mber, Cit	y or Town, Sta	ite, Zip C	ode)		
		Deborah Russ		ster)								1e, M				
and 2	- 1	20a. Method of Disposition		20b.	Place of Dispos	ition (Name			Dat			ocation - City				
Organia in the control in the contro		1 Burial 2 Crematio		from State C r	crematory or oth est La	ner place) LW N M (	em.	;	3-16	-12	Ma	rriot	tsvi	ille, MI		
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	- 1	4 Donation 5 Other S 21. Signature of Funeral Service			22. N	lame and Ad	ldress c	of Facility	Haig	aight Funeral Home & Chap						
	- 1	Parge Hargh		est	Р.	O. B	ох	195	Syke	svil	lle,	MD 2	1784	+		
Physician		23a. Part I. Enter the disease, o	r complications that		n. Do not enter th	ne mode of d	dying, s	uch as card	iac or resp	iratory ar	rest, sho	ck, or heart	App	roximate Interval		
/Medical.	- 1	failure. List only one cause Immediate Cause (Final disease		ensive A	therosc	lerot	ic (	Cardio	vasc	ular	Dis	ease	Det	Death		
<u>E</u> xaminer	- 1	or condition resulting in death)		a consequence		LCIOC		Julul	rabo	GLUL	220					
		Sequentially list conditions,	b										-			
	Ē	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.														
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
ox 68760, sath certificate be executed attending physician and or use as the burial - transit		d AMENDED 23a,pt.II,27,per me,g925 3-29-12 sm														
) oe exe ician (	dical	X UNPENDED	AMENDED	23a,pt.	11,2/,p	er me,	gyz	5 3-2	9-12	Sm						
760 icate l	₩	IF FEMALE: 23b, Was decedent pregnant in t	the common	, outcome of preg			2 [-	Testonia ar	oanana.			. Date of deliv Month	ery Day	Year		
6876( certificate nding phy:	ä	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)										MOTO	Day	Toda		
	Physician/Me	1 Yes 2 No 9 ✓ Unknown 9 Unknown														
that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  27e. Did tobacco use contribute to the cause of death?  27e. Did tobacco use contribute to the cause of death?  27e. Did tobacco use contribute to the cause of death?														
- 8 50 g	d by	Chronic Obst	ructive P	ulmonary	<u>Diseas</u>	e;Chr	onic	Narc	otic	1 Ye	s 2 _					
rds requi	ete	Use								24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of						
The cate	Completed									performed?   death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No						
		25. Was case referred to medical 26.Place of Death (Check only one)														
Vita hysicis this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	] ER/Outpatient	3 DO/	م ا ⁰	other4 N	lursing Ho	me 5	Reside	nce 6 Ot	ner:			
n of \ding Phy.  After the funeral	H	27 Mapper of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work?								28d. Describe how injury occurred						
on tending sath.	Ē	1 X Natural 5 Pending 1 Yes 2 No														
Division tal or Attendii s after death. al Director: A	ij	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)														
Division of Vital I the Hospital or Attending Physician: bin 24 hours after death. the Funeral Director: After this certifingletely filled in by the funeral director,	Certification:	4 Homicide determined (Specify)														
To the Hospital within 24 hours To the Funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
To the Hos within 24 h To the Fur	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)														
	Σ	29b. Signature and title of certif	er											zy, 1 car)		
, A		to V	- 10l	le_			D.C.N	I. C.			IVIAN	ch 14, 201: 		_		
Ot pare		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223														
1 10		Patricia Aronica-Polla				900 W. E	oaium	ore Stree	ei, daill	noie, N	או א טויי					
S	tate	31. Date filed (Month, Day, Year	לא לא	Registrar's Signa	ure Asala											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** BATTON MATTIE 2012 MARCH /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

April 20,1915 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 Virginia 96 218-82-9287 **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2X No Directo Dunda1k MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21222 United States 107 Wise Ave. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

int: If item 27 Is marked other than "natural", or items 23 any or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify þ Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Emma Garrison ည Clarence Austin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 2628 Rocks Road Forest Hill, Maryland Mr. Linwood Leroy Eatton (Son) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 3/17/2012 Gardens of Faith Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222
23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

As Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) difficile Physician 0 /Medical Due to (or as a consequence of) **Examiner** hroni < Llow Squantially list or dations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as 1 nding as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Day in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year ed by the at detached f Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown been sig should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b page 2 s 1 ☐ Yes 2 🗌 No 1 🗌 Yes certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \sum Nursing Home 2 X No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 1 Inpatient s after death.

| Director: After this do in by the funeral d this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation М 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide building, etc. (Specify) City or Town, State) within 24 hours aft

To the Funeral Dir

completely filled in (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 295-600

State Registrar

31. Date filed (Month, Day, Year) 5

MATTHEW

ETCKI, MIP 32. Registrar's gignatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

MARCH

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 130PM Physician/ March 20 Dorothy Marie Bahm Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Glen Burnie Baltimore Washington Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 89 183-14-3114 1 □ M 2 🛣 F Director Pennsylvania Sept. 3, 1922 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State notified at Director 1 🗌 Yes 2 💢 No Glen Burnie Maryland | Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral United States 21061 316 4th Avenue, SW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**X** No 3altimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. other than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homeowner Homemaker 12 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ಲ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Alice (Unknown) Robert Richard O'Brien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 316 4th Avenue, SW, Glen Burnie, Maryland 21061 Robert R. Bahm/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 🔀 Cremation 3 □ Removal from State Date 03/13/2012 Catonsville, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) S anature of Funcial orvice Licensee Name and Address of Facility rkley-Ruddick Funeral Home 21 Crain Highway, SE, Glen Burnie, Maryland 210 1 110136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a documento of) Examine day, leading to immedicause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown certificate has been signed by the a irector, page 2 should be detached 9 Unknow the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 DNO 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 🗌 Yes 2 L No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 4 Homicide City or Town, State) 24 hours Medical

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29a. Certifier

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29b. Signature and

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only one

Registrar DHMH 17 Rev 06-2011 Certifying Nurse Practitioner: To the best of my knowledge.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

of the time, date and clace, a

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:00P Warch William H. Blades, Jr. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Security Number **Funeral** (Month, Day, Year) Days Min 77 Director 214-32-1277 1 🕅 M 2 🗆 F 1934 Maryland June 20, Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location notified at Director 1 Yes 2X No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 9 ms 23a or must be r 21061 Funeral 501 Morningside Drive United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify.White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working fimore, Maryland 21215-0 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Self Employed Contractor 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil tment of Health and Mental rant: If item 27 is marked မ Pauline Furbush William Harry Blades, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5502 Whitehall Road, Cambridge, Maryland 21613 Robyn Edmondson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 03/16/2012 glen Burnie, Maryland 4 Donation 5 Other (Specify) Glen Haven Mem. PK. 21. Signature of Fu arabSrd ice ___ ensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Highway, SE, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause given the disease inc. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MOMM disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) been signed by the a should be detached 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy this certificate Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 1 Yes 1 hpatient 2 ER/Outpatient 3 DOA Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work?
1 \( \square \text{Yes} \) 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural (Month, Day, Year) iniury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 2

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State Registrar Name and address of perso

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who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 20b, per 5h, 9925 3-15-12
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Õ9 BENJAMIN MARCH 2012 05:30A PHYLLIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE CARE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Country) Director 219-48-6159 1 □ M 2 🗓 F 06/11/1947 NY 64 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at Director 1 X Yes 2 No or 28a-f N/A BALTIMORE MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Completed by Funeral 23a 500 W. UNIVERSITY PARKWAY, 21210 USA iral", or items 2 Examiner mus death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🗶 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) OWNER TRAVEL AGENCY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ **ADAM** BENJAMIN GLORIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALLAN ROSENZWEIG / HUSBAND 500 W. UNIVERSITY PKWY, #8-H, BALTIMORE, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State /14/2012 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) month Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Other (specify) Pregnant at time of death signed by the at d be detached for ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 No 3 Probably 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 2 s 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Yes 4 Nursing Home 5 Residence 6 the (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred After injury Natural 2 Accident 5  $\square$  Pending after death. Investigation by the 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a
To the Funeral I Medical "Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W N ST

State

Registrar

31. Date filed (Month, Dav. Year)

6701

HARVES

5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 MARCH 05:25P ^M BINSTOCK SYLVIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE PIKESVILLE POMONA EAST, #203 If Under 1 Year If Under Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Birthy Country) MD **Funeral** 1 🗆 M 2 💢 F Months Hours 1270671917 **Director** 215-10-5866 94 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 💢 No PIKESVILLE MD BALTIMORE 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1 POMONA EAST, 21208 USA #203 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. ☐ Yes 2 🕅 No Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY Elementary/Seconday (0-12) College (1-4 or 5+) 12 SECRETARY DEPT OF EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KOTZEN GERTRUDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN FLAX / GREAT NIECE 3403 OLD FOREST ROAD, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RUDOMER VEREIN 03/14/2012 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Puneral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or hear vailure. List only one cause on each lipe. Approximate Interval Between Onset and Death Chricle Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner moni Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a c equence of): Cause (Disease or iiniury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a gonsequence of) Completed by Physician/Medical 'lease. Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) 1 ☐ Yes ∠ ⊆ g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 → 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2 s autopsy Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital 1 Tes 2 🔁 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 \quad Yes 28d. Describe how injury occurred Natural Accident iniury 5 Pending 2 🗆 No Investigation within 24 hours after deatl To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Itert 23a) (Type, Print) 10 V

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen Michael Cordero 10. 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Ijamsville 9922 Fire Tower Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday, **Funeral** Days Hours Min. oct. 23 Mary Land 59 Director 212-64-7247 Usual Residence of Decedent 28a-f show be filed within 72 hours after death with the Maryland lental Hygiene.

Red other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at **Funeral Director** Ijamsville MD Frederick 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number traumatic event, the Medical Examiner must be USA 21754 9922 Fire Tower Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc 1X Yes 2 □ No Specify: Puerto Rican 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Parts 12 Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Pedro M. Cordero June P. Jones Page 1 and 2 should be tment of Health and Mer tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9922 Fire Tower Road Ijamsville, MD 21754 Teresa O'Rourke / sister injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 3/13/12 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licenses Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Q. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of Due to (or Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to for as a consequence on the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: If yes, cutcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? tor: After this certificate has been signed by the atter the funeral director, page 2 should be detached for it Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ည 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending injury within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date şigned (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Dav. Registrar's State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month March 12, Mary O'Neil Carter 1:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Martin's Home Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months **Director** 218-30-6379
Usual Residence of Decedent 1 □ M 2 😿 F 80 Aug 30, 1931 Maryland 28a-f show 10c. City, Town or Location with the Maryland at 10a. State 10b. County 10d. Inside City Limits Director notified MD Baltimore 1 ☐ Yes 2X No Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 601 Maiden Choice Lane 21228 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " ent, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) Inspector Electronics 12 other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any juiny or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William T. Carter Mary Catherine Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Eff/POA 16 Randall Avenue Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 03/15/12 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) Signat of Funeral Service Licen Gaing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph si ian a Metastatic Cancer disease or condition Medical resulting in death) Examiner Breast Cancer Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No be detached for Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed Morbid Obesity Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? Yes 2 XNo 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🕅 No မ 1 Inpatient 2 Impatient 2 Impatient 3 Impatient 2 Impatient 3 Impa 4 X Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? after death. the f 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and of certifie D21649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANSANDAM BASKARAN 3 455 Wilkens Ave Baltimore MD 21229 "AMBANDAM 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:01 AM 201 Robert M. Cluff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILDO 8. Date of Birth (Month, Day, ug 15, Funeral Year If Under 24 Hrs 9. Birthplace (State or Foreign Min. Months 1 □XM 2 □ F ^{Country)} Maryland Yrs. Director 1951 215-58-5860 60 Aug Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Times Sq. 21802 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by Yes Yes, Give Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) construction U welder Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Margaret Green Robert Lee Cluff injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 105 Crockett Ave #2D; Fruitland, MD 21826 Gary Cluff - brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signat re of the grad 1 1 dicen to 11e Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or teart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ARYNGRAC Physician CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and tran Due to (or as a consequence of): physician s the burial Physician/Medical that the death certificate be P.O. Box 68760 ding IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for us Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2/2 No 1 TYes 4 Nursing Home 5 Residence Other (Specify) HOS PICE မ in 24 hours after beganning the Funeral Director. After this connected filled in by the funeral director 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Acciden injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ap 29d. Date signed (Month, Day, Year,

State

SAZISBURY

21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHACFANT, DOROTHY 6

			Please Type or P					-	_	gible.	
			For State of I	Marylan	-	artment of H		/lental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eath	2. Date of De	Reg. No.	112	080/4
П	Physicia		Dorothy Elizabeth Chalfa	n+				Month	Day	Year	3. Time of Death 17:30 M
D.	Medic Examin		4a. Facility Name (if not institution, give street and number			4b. City, Town, or	Location of Death	05	4c. County		
mark.			SAINT AGNES HOSPIFAL			BAZTIMO	RE				
	Funeral Director		218-05-2718 1 □ M 2 <b>X</b> J F	Age (In yrs. Ia 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov 29	th y, Yea <i>r</i> ) , 1920	Cou	nplace (State or Foreign ntry) aryland
	ind show at	្រ	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryla 28a-f s atified	Director	MD Anne Arundel	На	anover					ŀ	1 ☐ Yes 2 🗶 No
	th the f		10e. Street and Number			10f. Zip Code 21076			10g. Citizen of USA	What Cou	intry?
	ath wi	Funeral	7414 Mulberry rd.  11. Marital Status 12. Was Deceder	t Ever in LLS	13 \	Was Decedent of His	spanic Origin? (Sp.	ecify Yes or No-		e - Ameri	ican Indian,
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Mportant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced  Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s? X No		f Yes, specify Cubai	n, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	, etc.
15-0	2 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occupa kind of work done d		ing	16b. Kind of E	Business/Industry	
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DI 2	be filed within ental Hygiene. ked other tha ic event, the N	Be	17. Father's Name (First, Middle, Last)			1	18. Mother's Nam	e (First, Middle,			
ylaı	ild be Menta narked artic e	욘	Charles Caret Kaiser				Sara C	ordelia	Green		
, Mar	id 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print)  Janice Hughlett – daught	er		ng Address (Street a					Code)
Baltimore, Maryland 21215-0036	Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 🕅 Donation 5 ☐ Other (Specify)		emetery, cren	sition (Name of natory or other place		Date	20c. Location		Fown, State
Balti	permit. Departr Imports any inji		21. Signature of Funeral Science Licensee Di	rector	22	Name and Addres	s of Facility St Baltimore				21201
	100.1		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final	sed the death ine.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
)	h_sician/ Medical		disease or condition	is a consequ	ence of):	TAILU	RE			-	40e125
	Examiner	Į.	Sequentially list conditions, b	669		HEURLY F	AWRE				YEARS
	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequ	ey A	etery	MSEXE	E			YEARS
											YEARS_
. Box 68760	of the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcon  1 ☐ Live Birt  4 ☐ Pregnan  9 ☐ Unknown	h 2 ☐ Fetal tat time of d	Ideath 3	Ectopic pregnanc Other (specify)	у		-	ate of deli	very Day Year
s, P.O	requires that the value of the control of the contr	by	Part II. Other significant conditions contributing to death								the cause of death?
Division of Vital Records, P.O.	sician: The law requirection to a specificate has been lirector, page 2 shou	Completed	ANEMIA						psy ormed?	prior to co death?	opsy findings available ompletion of cause of
alF	ilan: 1 artifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Chec		2 LFINO	1 🗀 103	
<u> </u>	Physic this ce ral dire	욘	1 Ves 2 No Hospital:		ER/Outpatier		r: 4 🗌 Nursing H	ome 5 Resi	dence 6 🗆 Oth	er (Specif	(y)
on of	eath. or: After t the funers	Certificate:	2 Accident Investigation	njury Day, Year)	28b. Time of injury	work'		28d. Describe I	now injury occur	red	
Divis	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the funer		4 Homicide / determined 286, Place of	njury - At hoi etc. (Specify)		eet, factory, office		28f. Location ( City or Tox		er or Rura	al Route Number,
	to the hospital or Attending Physician: which 24 hours after death. To the Inneral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of Certifying Nurse Practifioner: To	f examination	and/or inves	tigation, in my opinio	n, death occurred a	t the time, date a	and place, and du	e to the ca	ause(s) and manner stated.
	o the within 2 To the I		29b. Signature and title of certifier		M	29c. License	number 23624		29d. Date signe	d (Month,	Day, Year)
			30. Name and address of person who completed cause of ALFREDO WON TOUR MO	, 901	O CA	HON AU.	BALTIM	ore !	40 21	220	3
	Sta Registr	te ar	31. Date filed (Month, Day, Seat) 32. Regis	strar's Signat	fare	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08075 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Grace Callender 2012 March 10:25 P ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Health and Rehab Anne Arundel Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 212-32-8979 Director 1 ☐ M 2**X** F 97 June 15, 1914 Virginia show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Crain Highway, N 21061 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Various Companies Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ t. Page 1 and 2 should be threath and Ments reart. If item 27 is marked ijury or other traumatic e Walter Walgon Bessie Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Callender/Son 8092 Foxwell Road Millersville, Maryland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Glen Haven Memorial PK 03/12/2012 Glen Burnie, Maryland 21. Signature Ineral Service Licen 22. Name and Address of Facility rkley-Ruddick Funeral Home N 0136 Maryland 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a co Exami the burial-transit and that initiated events Due to (or s a consequence of resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Dav 5 Other (specify) Pregnant at time of death signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 2 No Yes 2 N 1 Yes within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural Hospital or Attending (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30641 20/2

DHMH 17 Rev 06-2011

State Registrar 201-109

Back Rowermeck Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saba

amesh

31. Date filed (Month, Day, Year)

palhi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 13, Physician/ Day 2012 Year Frances V. Caravello 10:55 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Baltimore Towson . Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 10/11/1937 215-34-8991 74 **Director** Maryland 1 M 2 X F Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2X No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 7307 Gunpowder Road 21220 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 🛣 No If Yes, Give Black White etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify. 3 Divorced 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F William J. Bauernschub Anna Schell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is Vincent Caravello (Husband) 7307 Gunpowder Road, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State injury or Holly Hill Mem. Gard. 03/17/2012 4 Donation 5 Other (Specify) Baltimore, Maryland Significant Filtred Segrecticens any in 22. Name and Address of Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final endonchial Onset and Death Ph, sician adenocananna CEINLA resulting in death) en 1 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (bras a consequence of, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 menths?

1 Yes 2 No Pregnant at time of death Month 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? 2 🗌 No Hospital or Attending Physician; 24 hours after death.
Funeral Director; After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Tes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence nospile Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MARCH 14 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Turson MM CHANCES AMON 610 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 0 3 Month OB 2012 1905p Stephen O. China Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Co. Windsor Mill Northwest Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 1 X M 2 🗆 F 3/06/2012 07/03/1950 Maryland 61 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 XYes 2 ☐ No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21207 U.S.A. 4 Retnue Ct. Apt4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc ō þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Black injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Quest Diagnostic Driver 12th Grade and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice Branch Odell China Tephen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trai 2407 Loyola Northway Baltimore, MD 21215 Lisa China(sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State on-site Crematory 03/15/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) For Brown Jr. Funeral Home PA neral Service Lic -2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Candiovascular Disease Artemosclerotu disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Dise to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death
Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by isorde 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 X No death? 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 
Yes 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 2  $\square$  No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat pleted cause of death (Item 23a) (Type, Print) MD rimb 31. Date filed (Moleth, Day, Year) 32. Registrar's Sig State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20a-c, perFH, G926, 4/10/2012, wS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 12, 2012 Anthony W. Christopher 3:48P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 79 577-82-0568 1 ★M 2 🗆 F 11-17-32 Grenada, WI Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 28a-f s XYes 2 No Takoma Park MD. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a ( Funeral 20912 402 Clayborn Avenue #2 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2X No Maryland 21215-0036 Hygiene. 1 Yes 2 YNo Specify. Specify: Black 3 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Security Officer 12th and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. ပ Joseph Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adelaide Christopher/Wife 402 Clayborn Ave., #2 Takoma Pk. Md 20912 Baltimore, 20a. Method of Disposition

The Disposition 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott Riverdale Park place) 26 Riverdale 4 ☐ Donation 5 ☐ Other (Specify) Heritage Memorial 3/<del>24</del>/1 Waldorf, 21. Signature of Funeral Service License 22. Name and Address of Facility Latimore Funeral Services, 2818- E. Baltimore St. Balt lt , Hackon Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as-a Exami and -tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ P in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 No Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, Completed 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed' death? certificate 2 🗌 No 2 No Yes Vita 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ After this Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at e Hospital or Attending P 124 hours after death. e Funeral Director: After the letely filled in by the funera 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) / and title of certifier 29b. Signature 29c. License 29d. Date signed (Month, Day, Year) 00 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen M. Kango, M.D. 7701 Carroll Ave. Takoma Pk. Md State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $12^{\!\text{Day}}$ Physician/ March Xavier Delea 2012 Francis 4:57 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Maples Assisted Living Facility Baltimore Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** Age (In yrs. last birthday) 8. Date of Birth Feb. 16,1923 Days 1 XM 2 □ F Hours Min 89 Director 215-14-4340 Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? Funeral 2828 North Wind Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. er than "natural", or i 1 

Never Married 2 □ Married þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 <u>Jeremiah John Delea</u> Catherine Gertrude Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jeanne Thompson / Niece 2828 N. Wind Rd., Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 03/14/2012 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc Doctin 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Ent., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ thrive -milure disease or condition resulting in death) TO mth Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ng physician and as the burial-transit death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No or Attending Physician; 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Assistad Living Hospital: 1 Tyes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other Spec this Heitilg 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completed filled in by the fi Accident Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of pertifier 25205 6701 N. Charles St. Balto. MJ 21204 who completed cause of death (Item 23a) (Type, Print) GBMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia 21:16 PM Louise Dascomb  $201\hat{2}$ Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shangri-La Assisted Living Howard Co. Ellicott City Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Dav. Year) Hours 217-56-4382 **Director** 1 □ M 2 🗓 F 97 03/25/1914 Maryland Usual Residence of Decede 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director MD Howard Co. Ellicott City 1 Yes 2 X No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4475 Montgomery Road 21043 United States items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Force P Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural" White Completed 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. the Homemaker Own Home vr. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be ment of Health and Menta W. Warfield V. James Grace Main 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Mrs. Jeraldine K. Jenkins/niece 946 Steamboat Lane Heathsville, VA 22473 item 2 20a. Method of Disposition
1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date cemetery, crematory or other place 4 Donation 5 Other (Specify) 03/16/2012 | Monrovia, Maryland Pleasant Hill Cem. Signature o veral vice 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ISCHEMIC STROKE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 nse ( 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy5 Other (specify) in the past 12 Months? Day Pregnant at time of death Month Year 9 🗌 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be No 3 Probably 4 Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy I Director: After this certificate had in by the funeral director, page performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Assisted ၉ 1 Yes 2 XNo Other: Nursing Home 5 Residence 6 HOTher (Specify 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Pactitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

Andrew Lazris, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D47447

6334 Cedar Lane #103, Columbia, MD

29d. Date signed (Month, Day, Year)

March 13, 2012

21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 3 55PM MARCH Edna May Durrant 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BURNIE BALTIMORE WASHINGTON MED GLEN ANNE ARUNDE Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 519-32-1533 1 🗆 M 2 🕱 F 79 April 17, 1932 Usual Residence of Decedent Idaho 28a-f show with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 No Maryland Anne Arundel Glen Burnie ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 904 Palm Tree Circle 21060 United States 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homeowner 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Othella Mae Parks Frank William Polatis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 904 Palm Tree Circle, Glen Burnie, Maryland 21060 Norman William Durrant/ Husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) 03/19/2012 Crownsville, Maryland Crownsville MD Vets 21. Sign Jure of Fune 22. Name and Address of Facility
Kirkley-ruddick Funeral Home
421 Crain Highway, SE, Glen Burnie, Maryland 21061 e Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPSIS .Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No Hospital or Attending Physician: The 24 hours after death.
Funeral Director, After this certificate the control of t 2 **X**No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier D0061832 2012 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

HOSPITAL DRIVE GLEN BURNIE, MD 21061

301

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death RCISON DWYER MARCH 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore Social Security Number 6. Sex Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours Mir 226-25-6975 1 □ M 2 🕅 F Yrs 45 08/08/1966 Virginia Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🔀 Yes 2 🗌 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 620 Fallsway 21202 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ... life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Dwyer / Husband 620 Fallsway, Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 03/14/2012 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) but to for as a consequence on Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE PULM aNAMY 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician/ Medical Examiner

attending physician and I for use as the burial-transit

be detached

signed by the

I or Attending Physician: The law requires that the death certificate be eafter death.
Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner

Completed by

Medical Certificate: To Be

(Check

filled in by the

within 24 hours a To the Hospital

Physician/

Examiner

**Funeral** 

Director

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and 2 should be filed within 72 hour Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical

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Important: If ite
any injury or otl

Page 1

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Director

Funeral

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Completed

Be

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with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Medical

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

24a. Was an autopsy performe

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1  Yes 2 No	Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)							
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death	h occurred at the time, date and place, and due to	the cause(s) and manner as stated
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, )
+ LEDATUS MD	D47934	MARCH 12,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

12,2012

P. A. M. S.	MO	227.	ST. PAUL PL	BALTIMORE MO	21206
Date filed (Worth Day Year)	32 Regi	etrarie Signature			

State Registrar

Dever S. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ε. Antoinette Funk 1 2ay MARCH 20⁴12 9:08A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours **Director** 212-60-9100 1 M 2X F June 22,1951 Maryland 60 Usual Residence of Decedent or 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Middle River MD Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral United States 21220 12 Oldfield Court 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Armed Force Black, White, etc. 1 Never Married 2 🙀 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Years Homemaker marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental I 1 and 2 should be find Health and Mental item 27 is marked 2 Betty J. Cromwell John F. Indolfi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Oldfield Court Middle River, Maryland 21220 Mr. Donald W. Funk (Husband) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place. 3/14/2012 Towson, Maryland Hilltop Service Corp; 4 Donation 5 Other (Specify) of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIPLE SYSTEM ORGAN FAILURE Physician disease or condition Medical resulting in death) **Examiner** SEPTIC SHOCK Sequentially list conditions, if any, leading to initilectate cause. Enter Underlying Due to (or as a consequence oi). Exami GROUP A STREPTOCOCCUS BACTEREMIA law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 s autopsy perform Hospital or Attending Physician: The Yes 2 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 X No ပ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW M.D. 7601 OSLER DRIVE, TOWSON, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death  $7:10 p_M$ Physician/ March 12ay Michael Farrell 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 911 W. Lake Avenue N/A Baltimore If Under 24 Hrs. 6. Sex If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign New York 054-28-3484 1 🛛 M 2 🗆 F Months Days Januar V^ay 1 e^{ar)} 1933 79 **Director** Usual Residence of Decedent or 28a-f show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 911 W. Lake Avenue 21210 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced Specify: Completed White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Roman Catholic Priest Church Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed f Health and Mental H item 27 is marked ot ပ Farrell Nora O'Sullivan 19a. Informant's Name/Relationship (Type, Print) Fellow Priest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert Street Baltimore, MD St. Joseph Society Sacred Heart 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary March 22,2012 Flushing N.Y. Cemetery 5305 Harford Road 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, Maryland 21214 tant L 23a. Part 1. Enter the disease, or complications U.a. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ( ) son line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last and trar Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decede 23d. Date of delivery 3 Ectopic pregnance in the past Year Day Pregnant at time of death 5 Other (specify) 2 No Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Ves Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, t 25. Was case referred to medi examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 2 - 1 ပ္ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 6 ☐ Other (Specify) 27. Manner Death Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No М Investigation Could not be , fam, street, factory, office 28e. Place of Injury - At home, building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Atate) determined building, etc. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100000, 40 21204 7600 ONEN Drive Suite 308 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

12-02117 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Laurene Franklin State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 13, 2012 **Medical Examiner** Hranklin Laurene 2120 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 219.92.911 Months Director Country) MD 1 M Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d, Inside City Limits NIA Baltimore 1 Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked uther than "natural", nr items 23a or 28a-f sho 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Street Orchard USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Black Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Baltimore, MD 21215-0036 12th arade Humemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chartes Bettz Laws Mary 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Sweet and Number or Rural Route Number, City or Town, State, Zip Code) 437 Orchard Stree . Franklin/Husband Baltimore MD 21201 Harold 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State nther crematory or other place) 1 Burial 2 Cremation 3 Removal from State Garrison Forest Donation 5 Other Specify 10 22. Name and Address of Facility Voyan C. Greene Fundal Savico Signature of Funeral Service License Road (Kandallotonn MD 21133 ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure, ist only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Morphine and Tramadol Intoxication Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g925 3-30-12 sm certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial -UNPENDED of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✔ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other₄ Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 X No unknown death. fd 3-13-12 fd 09:10 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 437 Orchard ST. Baltimore, MD. 3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Director: within 24 hours a

To the Funeral 1 Medical

Could not be

(Specify) Found: Residence

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

9b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
anet	O.C.M.E.	March 14, 2012

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Yea. State 5 Registrar

29a. Certifier 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per, doc g925 3-15-12 yt

			1 - For State Registrar	State	of Marylan		ártment of H tificate of L			giene 0   2	08086	
	Physici	an	Decedent's Name (First, Midd						2. Date of Dea		3. Time of Death	
	/Medic		ROBERT ALEXA						March	12, 2012	1:30P M	
	Examin	ner	4a. Facility Name (If not institutio	_	m <i>ber)</i>		4b. City, Town, or		h	4c. County of De	-	
			7049 Heathfield  5. Social Security Number	Road 6. Sex	7. Age (In yrs.	last hirthday)	Baltimo	re If Under 24 Hrs	8. Date of Birt		Itimore  Birthplace (State or Foreign	
	Funeral Director		220-46-2417	1 € M 2 □ F	63	Yrs.	Months Days	Hours Min.	07/17/19	L_Year)	aryland	
	2		Usual Residence of Decedent							-		
	anylar show		10a. State 10b. County			y, Town or Lo	cation				10d. Inside City Limits	
	8a-f	Director	Maryland Baltin	ore	Balt	imore					1 ☐ Yes 2√ No	
	with t		7049 Heathfield Roa	ad.			10f. Zip Code 21212	ī		10g. Citizen of What Country?  USA		
	eath	eral	11. Marital Status		edent Ever in U.	S 13 3	Was Decedent of Hi		necty Yes or No-		merican Indian,	
36	72 hours after death with the Maryland natural', or Hems 23a or 28a-f show disal Esantiat must be colified at	by Funeral	1 Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 ☐ Yes	orces? <b>XX</b> No ve		f Yes, specify Cuba 1 □ Yes ※XX No	Specify:	to Rican, etc.)	Black, W Specify:		
21215-0036	2 hou	ed		nt's Education	rutos.		edent's Usual Occupation			16b. Kind of Busine		
215	- * 0	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)	College (1-4or 5+)  (Give k life. D			e kind of work done during most of working DO NOT use retired)				
21	filed within Hygiene. other than	Con		4	,		Teacher			Public S	chool	
Maryland	ould be fill Menta! Hy arked oth atic even!	Be	17. Father's Name (First, Middle, Robert Roy Goll	Last)					me (First, Middle, izabeth Los	Maiden Sumame)		
Ž	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	2	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street a			r, City or Town, State	a, Zip Code)	
	1 and 2 Health ar Iem 27 is other trau		Amy Louise Pflaum		Sister		umleigh Roa					
Jre,	of Hea of Hea fitem r other		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place		Date	20c. Location - City	or Town, State	
Ē	0 0		XX Burial 2 ☐ Cremation Y☐ Donation 5 ☐ Other 6		State		Cemetery	03/16	/2012 E	Baltimore, M	aryland	
Baltimore,	permit. Pag Department Important: I eny injury o		2 ignature of Funeral co	Linsee Con	Penni	6/1) 22				defeld Funera Tyland 21212	al Home Inc.	
		-	23a. Part1. Enter the disease, o	complications that of	aused the death	Do not ent	er the mode of dying	, such as cardia	or respiratory ar	rest.	Approximate	
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on e	Ch rov	nic C	distract	ive Pa	ilmonar	y Diseas	Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to	(or as a consequence		ve Slee					
	p ti	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							radome		
_	and Ptrans	Examine	that initiated events resulting in death) Last	C	(01.20.2.000000	ionan of):						
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89	ifficate g phy as the	edlo		0.								
.O. Box	that the death certificated by the attending placed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	tcome of pregna birth 2 ☐ Fetal nant at time of de own	death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year	
Д.	es the	by	Part II. Other significant conditi	ons contributing to d	eath but not rest	ulting in the u	nderlying cause give	n in Part I.	23e. Did to		to the cause of death?  Probably 4 □Unknown	
Ö	w raquir been si should	etec		10,00	tine	Dep	endence	ie .	24a. Was		autopsy findings available	
Vital Records,	The lavate has	Completed		<del></del>					autop perfor	sy prior t med? death	o completion of cause of	
ta		0	25. Was case reterred to medica	ſ		/		26. Place of Dea	1 ☐ Yes		es 2 No	
	S 5 5	TOE	examiner?	Hospital: 1 🔲	Inpatient	<b>⊂</b> <del>EP/</del> Outpatien	t 3 DOA Othe	r: 4 🗌 Nursing H	lome 5 Resid	ence 6 Other (S	pecify)	
U O	ng Ph fter th		27. Manurer of Death  ☑ Natural 5 ☐ Pendir	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury occurred		
sio	Attending It death. ector: After by the fune	catl	2 Accident investi	gation not be				es 2 □No				
Division of	after of Direct	Certification:	4 Homicide determ	ined 28e. Place	e of Injury - At ho ing, etc. <i>(Specify</i>	me, farm, str	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier TV Certifyir (Check only one) 1 Medical	Examiner: On the b	e best of my know asis of examinat ner stated.	wledge, death tion and/or inv	occurred at the time vestigation, in my op	e, date and place inion, death occu	and due to the corred at the time, co	cause(s) and manner date and place, and d	as stated. ue to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of pertifie	-) M.	0.		29c. License	number 085	P P	29d. Date signed (Mo	3, 2012	
16	) 🗸		30. Name and address of person	who completed eaus	se of death (Item	234) (Type	Print) 760	Below	r Rd:	Baltimo	onth, Day, Year) 3, 2012 10, 140 21236	
	Sta Registra		31. Date filed (Month, Day, Year)		y kar's Signal	d. A	arke					

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			For	State of	f Marylar		artment of F		Mental Hyg	jiene	110	00007	
			State Registrar		<u></u>	Cer	tificate of E	Death		leg. No. 🚄	116	08081	
	Physicia	n/	1. Decedent's Name (First, Middle, L						Date of Deat     Month	Day	Year	3. Time of Death	
	Medic		Barbara Lee  4a. Facility Name (if not institution, g				41- Oito T	Lacation of Dooth	March		2012	1:35 P M	
	Examin	er	Carroll Hospit				4b. City, lown, or	Location of Death Westmins		1	4c. County of Death  Carroll		
	Funeral				7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign	
	Director		215-40-2432	1 □ M 2 😿 F	7	70 Yrs.	Months Days	Hours Min.	(Month, Day,		Count		
	p Mont	L	Usual Residence of Decedent  10a, State  10b, County			ty, Town or Loc	nation	<u>                                     </u>	May 14,	1941		/land Od. Inside City Limits	
	ne Maryland or 28a-f show notified at	Director		11	100.01	ty, rown or Loc		- *** 3				1 Yes 2 X No	
	he Mis or 28a		Maryland Car  10e. Street and Number	roll			10f. Zip Code	Windsor		10g. Citizen of	What Coun		
	with t	eral	2134 Old New	Windsor	Pike			21776			5.A.	-,-	
	tems er mu	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.	S. 13. V	Vas Decedent of Hi Yes, specify Cuba		ecify Yes or No-	14. Rac	e - America		
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	1 Never Married 2 XMarried	1 Yes	2 🔀 No		Yes 2 K No		nican, etc.)	Specify	ck, White, e		
Ö	ours a atural	Completed	3 Widowed 4 Divorced	Year or Da			lent's Usual Occupa				W	hite	
5	72 h In "ng Medic	mpl	(Specify only highest	grade completed)	\	(Give F	kind of work done d O NOT use retired)		king	16b. Kind of B	usiness/Ind	lustry	
212	within giene er tha		Elementary/Secondary (0-12)	College (1-	4 or 5+)		homema	ker			own h	nome	
D	filed wit al Hygie d other	Be c	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	ne (First, Middle, M	Aaiden Surnam	e)		
Maryland 21215-0036	2 should be filed within 72 hours after death with the th and Mental Hyglene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be not a second to the Medical Examiner must be a second to the second t	70	Albert H. Littl	е				Helen	Louise C	rawmer			
Mai	2 shou lith and 27 is n		19a. Informant's Name/Relationship				g Address (Street a				_		
	br real		C. Malcolm Garit  20a. Method of Disposition	y Jr./hus			Old New sition (Name of	Windsor	Pike Date	New Wir 20c. Location		MD 21776	
Baltimore,	permit. Page 1 ar Department of H Important: If iten any injury or oth once.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State (	cemetery, crem	natory or other plac				•		
Ħ	permit. P Departme Importan any injur		21. Signature of Funeral Service Lies		(a)		Cemetery . Name and Addres		/2012   rtzlor F	Westmir	uster,	, MD	
ñ	Der Imp	1	Mathanine (	). Xarl	Zer	4.5	10 Church		ew Winds			5	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.												Approximate Interval Between	
	Physician/		Immediate Cause (Final disease or condition			1451	40					Onset and Death	
	Medical Examiner		resulting in death)	Due to (c	or as a conseq	juence of):							
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (r	or as a conseq	mence off.	<u> </u>						
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	Duo 10 (1	7 45 4 551155Q	1401100 01/.					-8		
	cate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (c	or as a conseq	uence of):							
09	e be o	dical		d									
1/89	certificate be inding physici use as the bu	w I	IF FEMALE:										
×	ith cer ittendi	Physician/M	23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 Fet	aldeath 3 🗌	Ectopic pregnanc Other (specify)	у			ate of delive	ry Day Year	
Box	the atte	ıysic	1 ☐ Yes 2 🛂No 9 ☐ Unknown	g Unkn	ant at time of own	death 5	Other (specify)						
J.	The law requires that the death certific rate has been signed by the attending page 2 should be detached for use as	by Pł	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use cont	ribute to th	e cause of death?	
Š	uires l n sigr uld be	ed b							1 □ Y	es 2 No	3 🗌 Prob	ably 4 🗆 Unknown	
Š	w required is been 2 sho	Completed							24a. Was a		Were autop	sy findings available npletion of cause of	
ř	The la ate ha page	com							perform	med?	death?		
<u> </u>	sian: ertifica ector,	Be (	25. Was case referred to medical examiner?					ace of Death (Chec	k only one)				
≥	hysic this o	မ	1 Yes 2 No			ER/Outpatien		4 ☐ Nursing H	ome 5 Reside				
0	ding F h. After funer	ate	27. Manner of Death  1 Natural 5 □ Pending		h, Day, Year)	28b. Time of injury	28c. Injury work M 1 $\square$	≀at ? Yes 2 □ No	28d. Describe ho	w injury occurr	ed		
200	Atten r deat ctor:	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be 28e. Place	of Injury - At he	ome, farm, stre	eet, factory, office	les 2 🗆 NO	28f. Location (St	reet and Numb	er or Rural .	Route Number,	
Division of Vital Records,	s afte		4 - Nomicide determine	buildin	g, etc. (Specifi	y)			City or Town	n, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical					occurred at the time					d. se(s) and manner stated.	
	the L	Me	only one) 3 Certifying N				death occurred at the	ne time, date and p	ace, and due to the	e cause(s) and r	manner as s	tated.	
_	5.≱ <b>5</b> 8		29b. Signature and tile of partifier	Na	m)		29c. License	59550		29d. Date signe	a (IVIONEN, L	Ay, rear)	
			30. Name and address of person wh	o completed cause	of death (Iten	n 23a) (Tvne P	rint)			4/17	, 50/	~	
			C-OURISHPARAL	C. no	ANNA	DOU A	POOLE R	p WEST	MINSTER	2 mo	2115	7	
	Stat		31. Date filed (Month D5, 2012	32. Re	gistrar's signa	farle	,						
	Registra	ir	HAIL TO COLF	The same	1. (	1							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $03^{+} - 11 - 2012$ LaCreasha S. Greene 03:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours Director 215-06-3342 1 □ M 2 🛛 F 38 11-30-1973 Wash., DC show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f MD P.G. Oxon Hill 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? by Funeral 23a Page 1 and 2 should be filed within 72 hours after death with 1401 Deep Gorge Ct. 20745 U.S. ural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 X Yes 2 XNo Black, White, etc. 1₺ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 X No Specify: Black "natural" 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Unknown Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence Brown Wanda Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Wanda Flower Greene/Mother 112802 Babcock La. / Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 3-21-2012 | Landover, MD Harmony Mem. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latimore Funeral Services, PA 21. Signal di of Funeral Service Licensee 2818 E. Baltimore St./Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** IMMUNODEFICIENCY SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami use as the burial-transi and that initiated events Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has perform 1 Yes 2 No Yes 2 X No 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 X No ၉ 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc., (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

State

29b. Signatore and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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HANDVE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and I	Mental Hygien	ie						
			The ground in	rtificate of Death	Reg. N	<u>40. 2012 0808</u>	9					
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month     E	Day Year 3. Time of Death						
	Medic	al	Adrienne E. Hollis  4a. Facility Name (if not institution, give street and number)	Lu Ci T La dia d'Estit	March 11,	2012 2:15P ^N	Л					
	Examin	ier	Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	' '	4c. County of Death  Montgomery						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign	jn					
	Director		579-22-0749 1 □ M 2 🛣 F 89 Yrs.	Months Days Hours Min.	(Month, Day, Year, Mar. 21, 1	922   District of						
	nd how at	١	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lc.	pocation		Columbia  10d. Inside City Limits						
	larylar 3a-f s ified	Director	MD Montgomery Silver Sp			1 ☐ Yes 2 <b>X</b> N						
	the N or 28		10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?						
	is 23e	Funeral	3403 Saint Leonard Court	20906		USA						
	death r item iner n	/ Fui	Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.						
38	after al", o	d by	1 Never Married 2 Married 1 Yes 2 M No If Yes, Give Year or Dates.	1 ☐ Yes 2 🛛 No Specify:		Specify: White						
9	hours natur lical I	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industry	$\dashv$					
7	nin 72 ne. <b>han</b> " e Med	omp	Elementary/Secondary (0-12) College (1-4 or 5+)	kind of work done during most of work O NOT use retired)								
7	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho svent, the Medical Examiner must be notified at	Be C		maker	-	wnhome	4					
anc	oe file	To E	17. Father's Name (First, Middle, Last) Steven Luke Eilbacher	18. Mother's Nam Sue Mae	ne (First, Middle, Maide Estes	n Surname)						
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland is and Mental Hygiene.  7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at			ng Address (Street and Number or Rur		or Town, State, Zio Code)						
Ž	1 and 2 should be if Health and Men item 27 is marke other traumatic		r I	Saint Leonard Co								
Baltimore,			20a. Method of Disposition 1	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State						
<u>E</u>	trent of tant: If it idiury or o		4 Donation 5 Other (Specify) Final Jou	rney Crematory 3,	/13/12   Wo	oodbine, MD						
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Juneral Service Licensee M01651	2. Name and Address of Facility oing Home Crematic everly L. Heckroti	on Service te, P.A. Cl	P.O. Box 784 larksville, MD 2102	29					
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between						
~	h_sician/		Immediate Cause (Final disease or condition Acute Brain S	troke		Onset and Death						
-	Medical Examiner		Due to (or as a consequence of):									
		er	Sequentially list conditions, if any, leading to immediate b. Acute Renal F  Due to (or as a consequence of):	ailure			$\dashv$					
	nted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury  Arrhythmia									
	te be executed lysician and ne burial-trans	I Ex	that initiated events c. resulting in death) Last Due to (or as a consequence of):				$\neg$					
09		dical	d				_					
09/89	certifical nding ph use as t	Physician/Me	IF FEMALE: 23b. Was dependent pregnant. 23c. If yes, outcome of pregnancy									
	death ce	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	9	23d. Date of delivery  Month Day Year	Ī					
ā.	the de sy the	hysi	1 Yes 2 No 4 Pregnant at time of death 5 L									
Д О	law requires that the ras been signed by the s 2 should be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?						
ds,	quires en sig ould b				1 🗆 Yes	2 No 3 Probably 4 Unknown	n					
S	aw rei	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	,					
e Y	The ate h	Con			performed?							
<u>ra</u>	ding Physician: h. After this certific funeral director,	Be o	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:	26. Place of Death (Chec			-					
_	this alo	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 🗆 DOA   4 🗀 Nursing Ho	ome 5 Residence 28d. Describe how inju		-					
ou	ath. ath. r. Afte	Certificate:	1   Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	work? M 1 ☐ Yes 2 ☐ No		.,						
Division of	or Atte ter de irecto n by tl	and Number or Rural Route Number,	$\neg$									
בֿ	pital o											
	Hosp 24 hc Fune letely	ledic	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)									
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director, After completely filled in by the funer	2										
			M Kahmanan	D66372	3/1	1/12						
			30. Name and address of person who completed cause of death (Item 23a) (Type, F				$\dashv$					
			Majid Rahmanian, MD 1500 Forest Gle	and the second s	ng, MD 209	10	$\dashv$					
	Stat Registra		31. Date filed (Month, Day, Year)  NAR 1 5 2012  32. Registrar's Signature	have								
			A A A A A A A A A A A A A A A A A A A									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #15 Per ANA BD G925 3/15/2012 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year SYSVO. H255 620 OM morch 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death chery Chose Montgomen Chery Chasa CAR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) U.S. 4 1 □ M 2 🔀 F Days Hours 67 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Chevy Chass MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Jones mil MD 20815 U.S'A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 - Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and attending physician for use as the burial Division of Vital Records, P.O. Box 68760 certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Physician/

Medical

Examiner

**Funeral** 

Director

or 28a-f show

Director

Funeral

þ

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

Physician Medical

Baltimore, Maryland 21215-0036

ed	3 Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 🗓 N	lo Specify:		Specify: White						
Bet	15. Decedent's Ed	ucation de completed)	a. Decedent's Usual Occ	upation	16b. K	find of Business Industry						
To Be Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	Publice hor	e during most of working  O  O  O  O  O  O  O  O  O  O  O  O  O	" u	yonown						
Be	17. Father's Name (First, Middle, Last)	•		18. Mother's Name	(First, Middle, Maiden	Surname)						
은	Leopold H.R. Has	ss		Vera Ma	arie Rice							
	19a. Informant's Name/Relationship (Тур Leonard Rice – r		19b. Mailing Address (Stree 8 Mill Far	n Cir; St.	Route Number, City or Paul Minne	Town, State, Zip Code) esota 55127						
	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cernetery, crematory or other place)  20c. Location - City or Town, State											
76	21. Signature Runaral Service Litense Rona Li	ale, Divector	e and Address of Facility State Anatomy Board 5 W. Baltimore St; Baltimore, MD 21201									
67 B	23a. Part 1 Enter the disease or compl shock, or heart failure. List only on Immediate Cause (Final disease or condition	ications that caused the death. e caus each line. a. CSIS	Do not enter the mode of dy	ing, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death						
J.	resulting in death)  Du (or as i consequence of):											
kamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence:  Spinal	Steno	813.		years.						
dical E	resulting in death) Last  Due tq (or as a consequence of):  d											
ě	IF FEMALE:											
Medical Certificate: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 D No 9  Unknown	7	23d. Date of delivery Month Day Year									
ed by Pr	Part II, Other significant conditions con	use contribute to the cause of death?										
complet	Chranic &	nonheal	ing war	ind.	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?						
ě	25. Was case refer d to medical examiner?		26.	Place of Death (Check of		1000 0000						
2	1 ☐ Yes 2 🎢 No	lospital: 1	R/Outpatient 3 DOA	ther: 4 🔀 Nursing Hom	ne 5 Residence 6	6 ☐ Other (Specify)						
ficate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)			8d. Describe how injur							
I Certi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, offic	2	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medica	(Check 2 Medical Examin only one) 3 Certifying Nurse	cian: To the best of my knowled er: On the basis of examination a Practioner: To the best of my k	and/or investigation, in my opi	nion, death occurred at t	the time, date and place	, and due to the cause(s) and manner stated.						
	29b. Signature and title of Certifier  29c. License number  29d. Date signed (Month, Day, Year)  211112											
	30. Name and address of person who co	ompleted cause of death (Item 2		MAIN 1 FIZSBUR	R. TUL	1. M) 0878						

State Registrar 31. Date filed (Month, Day, Year) **MAR 1 5 2012** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11 Day 2012 201 March 3:33 L Herbert Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Gilchrist Hospice/Columbia Columbia Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 217-48-5254 1 🗆 M 2 🔀 F Director August 17,1951 Maryland 60 Usual Residence of Deceden 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 X No MD Howard Elkridge 10e. Street and Number 10f. Zip Code Ь 10g. Citizen of What Country? must be Funeral 6017 Hunt Club Road 21075 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Yes _2 🗶 No If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: White 3X Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Manager Education System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Phillips Marie Herzog 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2223 E. Baltimore Street, Baltimore Maryland 21231 Jennifer M. Herbert-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Gard Mar. 14,2012 Elkridge Maryland 22. Name and Address of Facility Ambrose Funeral Home Inc. hu 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hasto disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed by Physician/Medical Exam Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown within 24 hours after death.

To the Funeral Director; After this certificate has been sig completely filled in by the funeral director, page 2 should to Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSpice 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident Investigation 6 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

Registrar DHMH 17 Rev 06-2011 only one)

29b. Signature and title of certifier

JOSEPH 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

LANE.

D0060634

COLUMBIA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2012 9:58A March Gorton Humphrey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 41 WTTR Lane Westminster Carroll 8. Date of Birth (Month, Day, Year) Dec. 11, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours NÝ **Director** 1 □**X**M 2 □ F 1928 213-26-6184 83 Yrs 28a-f show 10d, Inside City Limits 10a State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Carroll Westminster 10e Street and Number 10a. Citizen of What Country? ö 23a Funeral 21158 41 WTTR Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3X Widowed 4 □ Divorced Completed Year or Dates. 1951-1955 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) 12 mechanic Electric Co. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o Natalie Sherman Gorton Hartley Cranston Humphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 North Court St. Westminster, MD 21157 William R. MacDonald/Pers Rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1 Decartment of I Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State All County Crematory: 3/6/2012 Sykesville, MD 4 Donation 5 Other (Specify) 21. Sign Jury of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the cuithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 🗆 Yes 2 🖃 No Yes 2 N funeral director, Be ( 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 6 1 🗌 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 2012

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

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wer how to

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ illiAm Month March 2012 0235 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hesp; ta 1timore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. I last birthday) 8. Date of Birth July 32 9. Birthplace (State or Foreign **Funeral** 214-26-850 1 X M 2 - F Country) **Director** Usual Residence of Decedent or 28a-f shov artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho: injury or other traumatic event, the Medical Examiner must <u>be</u> notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bultimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United State 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) rane Elementary/Seconday (0-12) College (1-4 or 5+) Operator 12 aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown UNKNEWN permit. Page 1 and 2 st.
Department of Health an.
Important If item 27 is m
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Cynnigham - Cave giver 1303 N. Lakeword 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State March 23 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re, f Funeral Service Licensee 22. Name and A dress of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) been signed by the atte should be detached for in the past 12 months? Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director; A 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Emma Delilah Jones Medical MARCH 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HICOMICO Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Date of Birth Months Days Min. (Month, Day, Year) Hours Director 212-16-1324 90 1 - M 2 X F Usual Residence of Decedent July 5 192 Pennsylvania 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2X No MD Wicomico Salisbury 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 31644 Johnson Rd. 21804 USA 12. Was Decedent Ever in U.S. Armed Forces ? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ò Black White etc. "natural", or 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 X Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) beautician cosmetology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Frances Shaffer and 2 should be in Health and Menta Lowman Luther Ott 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 31648 Johnson Rd; Salisbury, MD 21801 Bonnie Lavish - daughter item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State o - i 1 

Burial 2 

Cremation 3 

Removal from State Department o Important: If any injury or once. cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signat 22. Name and Address of Facility State Anatomy Board 655 W. Batlimore St; Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ I scheme disease or condition resulting in death) Hemmurken Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) physician a Be Completed by Physician/Medical Box 68760 as the attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a ld be detached f 1 Yes 2 L 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, completely filled in by the funeral director, page 2 should 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 💢 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director; After Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar and address

Hudson

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31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 27,28a-f per me,8925,03/22/2012dhb

Reg. No. 1 - For State Registrar 08095 Reg. No. 20 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Physician/ Month 1^{Day} 2012 Mathes Lee Johnson March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Havre de Grace Harford Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 710-09-6981 1 🖁 M 2 🗆 F 94 Director Carolina 4/15/1917 Usual Residence of Decedent 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Aberdeen 1 Yes 2 No Harford Maryland 10g, Citizen of What Country? 10e, Street and Number ŏ 10f. Zip Code 21001 permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene.

Department of Health and Mertal Hygiene.

Department of Health and Mertal than "natural", or items 23a or more than "natural", or items 23a or marked other than "natural" or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be a Funeral 147 West Deen Avenue Was Decedent - Amed Forces?

1.E. Yes 2 No 38 – 58 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.
Specify: White 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Military Serviceman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Dula ೨ Zollie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 147 West Deen Ave, Aberdeen, MD 21001 Walter L. Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3/17/2012 Aberdeen, MD Harford Mem.Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 bosus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death ACUTE SUBDURAL HEMATOMA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ACUTE DELIRIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) OFFICATION APPROVED BY NEDICAL EXAMINER the attending physician and the or use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PEMORAL NECK FRACTURE 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been signamentately filled in by the funeral director, page 2 should t Completed ERYPHEMA MULTI PORME 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed PAROXYSMAL 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 XNo 03/11/2012 1:00 a.™ Subject fell. 2 X Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **501 South Union** determined Hospital Avenue, Havre de Grace, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 29c. License number 29d. Date signed (Month, Day, Year) D08096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 Filard Ave Bel Air mp 21014

Registrar
DHMH 17 Rev 06-2011

State

MAR 1 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 11 pay Physician/ 2012 5:46 PM Lillian M. Juarascio Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford Examiner Upper Chesapeake Medical Center Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 82 213-26-2597 Director 1 □ M 2 🔀 F 7/23/1929 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director Forest Hill Maryland Harford 1 🗆 Yes 2X No 10f. Zip Code o 10e. Street and Number 10g. Citizen of What Country? 23a USA 21050 329 Bynum Ridge Road "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. by 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 SpecifwWhite XXWidowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I onee. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jenny Stewart Paul Hemling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3740 Ady Rd, Street, MD 21154 Virginia Schlerf 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, 1 Burial 2 X Cremation 3 Removal from State 3/14/2012 Pennsylvania .A.Ferris & Co. 4 Donation 5 Other (Specify) 21. Signatur Tarring-Cargo Funeral Home, 333 S. Parke St, Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Ons t and Death Aartic Aneurysm Prupture Immediate Cause (Final Physician/ Abdominal disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury pertension that initiated events resulting in death) Last Die to (or as a consequence of): attending physician at for use as the burial Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Pregnant at time of death 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ongestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed HYPOTHYROICHSM 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical examiner?

1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) Be Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manne of Death 28a. Date of injury 28b. Time of Certificate: 28d, Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) Hospital 1 Vertifying Physician Tourn best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On e basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Norse Pracutioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) march 13,2012 D0030653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 520 upper Chesapeake Drive Bei Air MD 2012 State Registrar C DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_ 1	For State Registrar	State of Marylar	•	artment of F rtificate of E			giene Reg. No. 2	012	08097
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month MARCH		2012	3. Time of Death
-4.	Medic Examin	al	ALMA SILVERMA  4a. Facility Name (if not institution, give stre		N	4b City Town, or	Location of Death			2012 unty of Death	5:45 P M
بعريبي.	Examin	eı	7 SLADE AVENUE, #			BALTI			BALTIMORE		
	Funeral Director		220-12-9322	7. Age (In yrs. )	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt		9. Birthp Coun	lace (State or Foreign try) MD
	and show lat	or	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryl 28a-f otifiec	irect	MD BALTIMO	RE	BALTIN						1 ☐ Yes 2 🂢 No
	ith the 33a or t be n	ralD	10e. Street and Number	0.0		10f. Zip Code	0		Ü	of What Coun	try?
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	7 SLADE AVENUE, #4	. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		USA Race - Americ	an Indian,
Maryland 21215-0036		by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates.		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Rican, etc.)	Specify:		etc. HITE
15-0	72 hou n "natu ledica	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done o		king	16b. Kind	of Business Inc	dustry
212	within giene. er thar , the N		Elementary/Seconday (0-12)	College (1-4 or 5+)	1	O NOT use retired) CRETARY			I	INSURANCE	
gud	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surr		IMPO CET
ĬŽ	ould b nd Mer mark imatic		CHARLES  19a. Informant's Name/Relationship (Type,		WEISSMAN  19b. Mailing Address (Street a		MINNI		r City or Tow		STFOGEL Code)
M.	nd 2 sh salth ar n 27 is er trau		MALCOLM KATZEN/HU		100	LADE AVEN					
Baltimore,	age 1 an ent of He nt: If iten y or oth		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	Place of Dispo cemetery crep ARLING	osition (Name of matory or other plac ION CHIZU CEMETERY	K oa/	Date		ion - City or To	,
altin	permit. Pa Departme Importan any injuri once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Society Licenses		22. Name and Address of Facility SOL LEVINS 8900 REISTERSTOWN ROAD, P					-	INC.
	70 E # 9	Н	23a Part 1 Poter the disease or complica	etions that caused the dea						ILLE, M	ID 21208 Approximate
politic.	Physician/		23a. Part 1, Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final disease or condition		an Car				,		Interval Between Onset and Death
way and	Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
	ed isit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or linjury	Due to (or as a conseq	uence of):						
	icate be executed physician and s the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a conseq	e to (or as a consequence of):						
160	ate be ohysicia the bur	dica	d.								
687	certific inding puse as		IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregna	2 Fetal death 3 Lectopic pregnancy				23d	I. Date of delive	ery
Box	he death y the atte iched for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown					Month		Day Year
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contr	ibuting to death but not re	sulting in the u	underlying cause giv	ren in Part I.				ne cause of death?
ecord	e law requ s has beer ge 2 shou	Completed							rmęd?	prior to co death?	psy findings available mpletion of cause of
al B	ian: Th rtificate tor, pa	Be Co	25. Was case referred to medical			26. Pl	ace of Death (Chec	1  Yes	2 <b>X</b> No	1 🗌 Yes	2 L No
ſ Vit	hysici this ce al direc	၉	1 LI Yes 2 KU NO	npatient 2			4 ∐ Nursing H	ome 5 Resid			)
o uc	nding F ath. r: After I e funera	icate:	27. Manner of Death  10	28a. Date of injury (Month, Day, Year)	28b. Time o injury	work	/ at ? Yes 2 □ No	28d. Describe h	ow injury oc	curred	
Division	al or Atte s after de I Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location (S City or Tow		umber or Rurai	Route Number,
	te Hospit n 24 hour e Funera	Medical	(Check 2 Medical Examiner	an: To the best of my know On the basis of examination Practioner: To the best of m	on and/or inves	stigation, in my opinio	on, death occurred a	at the time, date a	nd place, an	d due to the ca	use(s) and manner stated.
_	To the within To the comp	-	29b. Signature and title of certifier	as MD		29c. License	number		29d. Date si	igned (Month,	Day, Year)
	100		OO No for a distance of mercon who com	ploted agues of death (Itar	n 23a) (Type, I	Drint\					
	100		SYED ABBAS 670	1 N Charle	's St	Suite 410	5 Bal	timore	MD .	21204	٠.
	Sta Registr		31. Date filed (Month, Day, Year)  NAR 1 5 2012	32.'Registrar's Signa	ature	Val					

amend #9,11,12,15,16a&b,17,18,&19a&b Per ANA BD 9925 3/15/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2-5°9" 0401 Howard Leach Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince 6 corges hever 5. Social Security Number unkl 6. Sex If Under 1 Year | If Under 24 Hrs. ae (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director 65 1 X M 2 - F Jan 1, 1950 North Carolina Usual Residence of Decedent 28a-f show 10a. State with the Maryland at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗌 Yes 2 🗓 No DC 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be r Funeral 5010 Sheriff Rd NE 20019 death 12. Was Decedent Ever in U.S. Armed Forces? **unk** 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify black Specify 3 XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation unk 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene, is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk 5 unk 0 Laborer Construction event. Be filed 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or one ည pe t Lassiter Leach Dora McLean 19a James's New Chionship Tro Chier 1902: Pthes Coned Aver of Rever by Hour City 3001 Hospital Dr. Cheverly, The 20785 Prince Georges Hospital Ctr. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 Nother (Specify) in state Ronald 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Baltimore, MD 21201 23a. Par Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Arterioschen Immediate-Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence on burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day Month Year Pregnant at time of death detached been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe c Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an to the Frosphar Safer death.

Within 24 hours after death.

To the Funeral Director: After this certificate has be the Funeral Director. After this certificate has been seen to the funeral director, page 2: autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 1- Natural 5 Pending 2 Accident Investigation 1 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 2012 55 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete and 3001 5 2012 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death March 20T2 10:05 PM Sarah Katherine Landauer 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Frederick St. Catherine's Nursing Ctr. Emmitsburg If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day Year) g 2, 1925 Hours Maryland 86 218-24-9554 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 USA 35 S. Market St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2X No Black, White, etc. 1 X Never Married 2 Married Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Louella Sitz Irving Michael Landauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2142 Branard St; Houston, TX 77098 James Spence - nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rona re State Anatomy Board 22. Name and Address of Facility 655 W. Batimore St; Baltimore, MD 21201 Part 1\Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, & heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director; After this certificate has been signed by the attending physician and attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760 signed by the a should cate has page 2 s funeral director, completed filled in by the

Physician/

Medical

Examiner

**Funeral** 

Director

or 28a-f show notified at

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permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1

Physician

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examine

by Physician/Medical

Completed

Be မှ

Medical Certificate:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of):   sase	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy  1	23d. Date of delivery  Month Day Year
A : - /	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death (Checospital:	k only one)
1 L Yes 2 No	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing H	ome 5 Residence 6 Other (Specify)
27. Manner of Death  1 Valuatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of injury (Month, Day, Year)  28b. Time of injury  28c. Injury at work?  1 ☐ Yes 2 ☐ No  28e. Place of Injury - At home, farm, street, factory, office	28d. Describe how Injury occurred  28f. Location (Street and Number or Rural Route Number,
29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	building, etc. (Specify)  cian: To the best of my knowledge, death occured at the time, date and place, are: On the basis of examination and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certific

within 2

Registrar DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELLE DOBERMAN, MD

31. Date filed (Morith, Day, Year)

MARCH 14, 2012

6336 CEDAR LANE COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 12,20a-c,22,per fh,g925,3-15-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Cleveland Edward Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec 3, 1944 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 🛛 M 2 🗆 F North Carolina Dec Director 67 212-44-4474 Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Director 1X Yes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21206 USA Funeral 4406 Belair Rd. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Arrored Forces?

1 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: Black If Yes, Give 1969-1973 Year or Dates. 1 ☐ Yes 2 🔀 No Specify. Completed 3 🗌 Widowed 4 🗆 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Kind of Business Industry United States المالية. عال Hygiene. اعد than "r Elementary/Seconday (0-12) College (154 or 5+) Postal Service post master n and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Mae Lister permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or a simple of the state of th 2 Willie Lee 19a. Informant's Name/Relationship (Type, Print)
Frances Feagin - wufe 19b. Mailing Address (Street and Number or Rural Route Number, City or Tawa State, Zip Code)
4406 Belair Rd; Baltimore, MD 21206 altimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ther (Specify) in state 3/19/2012 Crownsville VA Cem. Crownsville,MD 22. Name and Address of Facility State Anatomy Board Park Heights John L. Williams Funeral Home 4517 Park Heights 655 W. Baltimore 51, Rairimore; Md. 27275 Ave. Ronald Solvice License 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Pnysician/ Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IE EEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ple 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to make al filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 No Medical Certificate: To 1 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner ath 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 14 Natural Accident iniury 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15150 ,2012 9540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

era filed (Month, Day, Year)
MAR 1 5 2012

31. Date filed (Month,

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State of	Marylan		rtmen tificate			Mental Hy	/giene	010	0.0	100
	-	Registrar  1. Decedent's Name (Fig.	rst. Middle, Last.		· · · ·	Cer	шсац	OT D	eatri	2. Date of D	Reg. No.		3. Time of I	Dogth
Physici Medi		Emma	Lentz							Month	Dav	Year 2012	11:19	
Exami		4a. Facility Name (if not Anne Arund	, 0					Town, or lapoli	ocation of Dea		4c. Cour	nty of Death		
Funeral Director		5. Social Security Numb 212–36–633 Usual Residence of De	0 1	М 2 💥 F	7. Age (In yrs. Ia 73	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min			9. Birtl Cou	hplace (State or Intry) MD	Foreign
aryland ia-f show ffied at	ector	10a. State 10	o.County nne Arun	ıdel		y, Town or Loc n Burn			·				10d. Inside City	
with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number					10f. Zip 210	Code <b>)61</b>			10g. Citizen o USA	of What Cou	untry?	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	ed by Fun	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	2X Married	12. Was Deced Armed Ford 1  Yes If Yes, Give Year or Dat	2 <b>X</b> No	If		ify Cuban	, Mexican, Puer	Specify Yes or No to Rican, etc.)		lack, White	ican Indian, , etc. ite	
21215-0036 within 72 hours after giene. her than "natural", o t, the Medical Exam	Completed		5. Decedent's Edi only highest grad ary (0-12)		4 or 5+)	16a. Deced (Give k life, DC Secre	ind of wor NOT use	k done du	tion Iring most of wo	orking	16b. Kind of		,	
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altimore, mit. Page 1 and partment of Hea portant: If item y injury or other		20a. Method of Disposit 1 Deurial 2 X C 4 Donation 5	Premation 3 🗆		State 20b. P	lace of Disposemetery, crem Arunde	sition (Name latory or ot L Cre	ne of ther place ematic	ry 03/1	Date 5/2012	20c. Location	-		
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Division of Vital Records, P.O., I To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed	Cerebra End si	ege r	erai	disc	es c				24a. Wa: auti per	s an 24 opsy formed?	prior to d death?	copsy findings a completion of ca	
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f VIII Physic	မြ	1 ☐ Yes 2 ☐ No 27. Manner of Death	•	ospital: 1 🔲 I 28a. Date o	npatient 2	ER/Outpatien 28b. Time of		Other 8c. Injury	4 ☐ Nursing	Home 5 Res			ify)	
on o	icate		Pending Investigation		h, Day, Year)	injury	M Z	work?		28d, Describe	how injury occ	urrea		
Division of V tal or Attending Physics after death.  In Director: After this ed in by the funeral d	Certificate:		Could not be determined		of Injury - At ho g, etc. (Specify		et, factory	, office			(Street and Nur wn, State)	mber or Rur	al Route Numbe	er,
the Hospit nin 24 hour the Funera	Medical	only one) 3 🗆	Certifying Physi Medical Examin Certifying Nurse	cian: To the beer: On the basis Practitioner:	est of my knowl s of examination To the best of n	ledge, death on and/or investing knowledge,	death occu	urred at the	e time, date and	, and due to the d at the time, date place, and due to	the cause(s) an	d manner as	s stated.	ner stated.
To vith		29b. Signature and title	0	y.	4		_	License			29d. Date sig			1 3
		30. Name and address	of person vibo co	mpleted cause	e of death (Item	1 23a) (Type, P	rint)		7531		17476	ח י ד	2110	1 6-
		mohit	- Neg	1 86	01 Ve	Terar	BH.	wy.	mill	45010	10,0	ND	2110	8
Sta Regist		31. Date filed (Month, D	of person who co	32. Re	gístrar's Signat	Lark	1							

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For		State of M	State of Maryland / Department of Health and Mental Hygiene												
		State Registrar		-41	Certificate of Death							Reg. No. 2020					
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LXAIIIII	CI.	Howard Co			Columbi		TO BOULT			Howar							
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and show	tor	10a. State		10c. Cit	y, Town or Lo	cation			1		1	0d. Inside City Limits					
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ırs aftı ıral", I Exar	ed k	3 Widowed	3 ☐ Widowed 4 Divorced If Yes,				1 ☐ Yes 2X N	lo Specif	fy:			Specify:	te				
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shoul and is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)															
and 2 Health em 27 ther t		Ellen R. Watsic/mother 9249 W. Stayman Dr., Ellicott City, MD 21042  20a. Method of Disposition 20b. Place of Disposition (Name of 20b. Date 20c. Location - City or Town, State												· ·			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🗓 Burial 2		Removal from State	0	emetery, crer	matory or other p		3/15	•		Location - Cit					
artine Poartine Sortan		21. Signature of Fu			Dul		Valley Mo										
lmp any		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093															
		23a. Part 1. Enter-the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between															
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l or At after d Direc	Cert	4 Homicide	determined	building, et	me, farm, str	eet, factory, office	9		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
the Ho lin 24 the Fu	Med	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certified Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
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~ <i>9</i> 1		30. Name aftd addre	ess of person who	completed cause of c			C+da	er la	ne								
Stat		31. Date filed (Mont)		32. Registr	ir's Sign	mt~(								· · · · · · · · · · · · · · · · · · ·			
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Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year larc 2012 ame. nhon 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 0 Under 24 Hrs. Min. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign If Under 1 Year last birthday) 5. Social Security Number 7. Age (In vrs. 6. Sex Year G Months Days Hours 1**№** M 2□ F Yrs 678 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 ☐ No ud 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 0 12. Was Decedent Ever in U.S. Armed Forces? 1 M2Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No Specify. Specify: /2 Slack 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ruard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Boone hoi 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State 20c. 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Vet Cem Salto. 4 □ Donation 5 □ Other (Specify) 21-2012 Funeral Service Balto. Ud. 2121 21. Signature of Funeral Service License Balto 1701 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ate Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Per /101d Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 Other (specify) □Yes 2□No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an bacco autopsy performed 1 ☐ Yes 2 ☐ No

1 □Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

ò

Completed

Be ဥ

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examines must be notified at

1.2 should be filed within 7 h and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

and burial-trar the attending physician the use detached signed by t be detach page 2 should peen has

law requires that the death certificate be executed

P.O. Box 68760,

Examine Certification: To

Physician/Medical þ Completed Be

Division of Vital Records, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate h completely filled in by the funeral director, page

Registrar

State

Medical

RobertA 31. Date filed (Month, Day,

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

2 No

5 Pending investigation

6 ☐ Could not be

M 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

N. Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 12, 2012 ACKERMAN MAGRAM 10:25 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1 GRISTMILL COURT, #108 BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Director 096-20-4173 86 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔽 No BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? Funeral 1 GRISTMILL COURT, #108 21208 USA ural", or items 2 LExaminer mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. Armed Forces?

1 Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes Give 3 ¥ Widowed 4 □ Divorced Completed WHITE event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ NATHAN ACKERMAN LOTTIE STONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YALE MARTIN MAGRAM/SON 3611 GARDENVIEW ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 03/14/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Scatt WL 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMON ARY Physician/ EDEMA disease or condition MINUTES Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Illnknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed? Yes 2X No Jas the Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier Yale martin magram Mo D15540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 ARD 6NVIEW ROAD BALTMORE, MD 21208

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Month, Day, Year)

5 2012

Box 68760

P.O.

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number) Examiner rdallstrum sautin day TOWY MI Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex . Social Security Number **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 4-7-1928 VIRGINIA Director 83 227-30-7470 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director BALTIMORE MD. N/A10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 USA Funeral 5440 NELSON AVE. death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after fXXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify BLACK Specify: 2 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GIANT FOODS DELI -10--0-Health and Mental Hygid tem 27 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN Be SADE BUSBIE ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5442 AUTUMNFIELD CT. ELLICOTT CITY, MARYLAND 21043 SHERMAN POPE (STEPSON) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 ☐Burial 2 ☐Crem 6 Department of Important: If any Injury or once, 3-16-2012 BALTIMORE, MARYLAND DRUID RIDGE CEMETERY 5 her (Specify) 4 ☐ Donation secJONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signat 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death The rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician WKILDUM /Medical Due to (or as a consequance of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physiciar Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 NUnknown been sig Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 si autopsy perforn or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner / 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 🗆 No 2 Accident death. Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) ature and title of certifie

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc 9926 4-9-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ 4:42р м Mihalik John Jr. March 11, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin Atlantic General Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 212-32-5268 August 26, 1936 Maryland 75 1**X** M 2 □ F **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Pittsville Md. Wicomico 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral USA 21850 34325 Old Ocean City Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Black, White, etc 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 9 years College (1-4 or 5+) Maintenance Mechanic Chemical Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Clark permit, Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John William Mihalik Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Mihalik Wife 34325 Old Ocean City Rd. Pittsville, Md. 21850 2012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 16, 1 X Burial 2 Cremation 3 Removal from State Parkville, Maryland Moreland Cemetery 2012 4 Donation 5 Other (Specify) 21. Signature of Fyneral Service Licensee 2. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, stody one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List Interval Between Onset and Death Cdff Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, reading to his rediate cause. Enter Underlying Examine Due to for as a consectioned off Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 00 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. W. Mihalik ş 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy death? performe Hospital or Attending Physician: The 24 hours after death, Funeral Director: After this certificate h Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗆 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Certifying Pysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical F aminer: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and title of cert 3/11/12 53612 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

ANGEL V. Bater MD 9733 Heal Whym Dr Berlin MD 218/1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | 2 State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of Death										Reg. No.							
Physicia Medical Examin	n/	1. Decedent's Name David K		_	Ong								2	Date of Month March		Day Yea	ar	3. Time of Deeth 1530 hrs	
		4a. Fecility Name (i	if not institution	n, give		d number)  4b. City, Town, or Location  Clarksville					ocation of	Death	- Indian	1, 20	4c. County of Death				
Funeral	4	5. Social Security N		7. Age (In yrs. last birthdey)			dev)	If Under 1 Year If Under 24Hr			24Hrs.	8. Date	of Birth	1	1 9. Birt	hplace (State or			
Director		215–60–8			Sex 7. Age (In )			88 _{Yrs}		Months Days Hours Mir		Min.	Oct 5, 1		Foreig		n untry) China	ι	
ħ.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d												10d. Inside City L	imits					
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Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code 21029												10g	. Citizen of Wi	nat Cour	ntry?		
5-0036 ed within 72 hours after death with the Maryland Jygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.		5900 Cli	fton O	aks	Drive					2102	29				US	SA 			
ith with	Funeral	11. Marital Status  1 Never Marrie	ed 2 XM		12. Was De Armed F	orces?	_	S.				anic Origi Mexican,					e - American Indian, Black, e, etc.		
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21215 wild be file Mental H marked c	Be	(unk)						Lie		nk)		(unk)						(un	k)_
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	ıŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City																	
Baltimore, permit. Pages I ar Department of Hee Important: If itel Imjury or other tr		1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 03/15/12 Woodbir										ne, MD							
Salti ermit. epartm mportu ijury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Going Home Cremation Service P.O. Box 784																	
Physician	-	23a. Part I. Ent of the	ne disease, or	complic	cations that	aused th	MO12 ^t ne death.	51 Do not	Beve enter the	e mode of	T. I	Heckr uch as ca	rdiac or i	e pirator	Δ y arres	Clarks t, shock, or he	<u>vill</u> art	Approximate Inte	terval
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Box 687 e death certifithe attending ed for use as t	Physician	4 Pregnant at time of death 5 Other (Specify) 9 Unknown																	
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Division of N pital or Attending Phours after death. eral Director: After t		27. Manner of Deat	th 5 Pen	al:	28a. Date (Mont Feb 27	of Injury h, Day Yes 2012		28b. T 1900	ime of Inj hrs	ury 2		at Work? es 2 ✔	le	8d. Desc ubject		w injury occum	ed		
Division tal or Attendi rs after death. al Director:	E a f	2 🗹 Accident	Inve	stigation	n 28e Pla			me, far	m, street	, factory,		ilding, etc		8f, Locat	ion (Str	eet and Numb	er or Ru	ral Route Number,	City
Div	Certification:	3 Suicide 4 Homicide		id not be rmined		Side	walk						5	or To	wn, Staton Oa	te) ks Drive, Cla	ırksville	, MD	
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To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.  29b. Signature and title of certifier								number					Date signed (Month, Day, Year)				
		Allan Brail MO											March 13,	2012	12				
	-	30. Nan and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223																	
	ate						Signatur		, VV.	שמונוווו		GOI, DO		2 سالا، , د				<del></del>	- 2
Regist	rar	31. Date filed (Mon	K 1 5	2012	Den	wa	A.	4	Park	d									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012 March Ursuline Purnell 14 12:24 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Min Hours 216-14-8560 **Director** 88 1 □ M 2 🗶 F Washington DC July 3,1923 Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location with the Maryland Director notified 1 🗌 Yes 2🏋 No N/AMaryland Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 2725 Walbrook Avenue - H502 21216 United States items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 14. Race - American Indian, Black, White, et Completed by 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 Native 1 Yes 2 No Specify. 3 Widowed 4 Divorced American Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenace Janitorial 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ Lemuel Fentress Mamie Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Harp / Grandson 1008 Charles Avenue, Charlotte, NC 28205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc |03/14/2012 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Eliker the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final set and Death Physician/ lawy Or disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 X10 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performa 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home 5 \( \triangle \) Residence 6 \( \triangle \) Other (Specify) Certificate: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending Investigation work? 1 ☐ Yes 2 ☐ No after death. Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 ... 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

o 2012

101

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANVES

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32. Registrar's Signature

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:18 PM Piper John Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore University Maryland Medical Center 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 213-94-4328 Director 1**X** M 2 □ F 32 3/24/1979 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director notified 1 X Yes 2 □ No Harford Aberdeen MD 10f. Zip Code 10e. Street and Number items 23a or ner must be n ö 10g. Citizen of What Country? Funeral 21001 USA 420 Doris Circle death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö Never Married 2 ☐ Married þ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify.White "natural", Completed 3 Divorced 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Building 11 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dianne Baker John David Piper, Sr. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Piper Gross/G. Mother 420 Doris Circle, Aberdeen, MD 21001 Baltimore, 20c. Location - City or Town, State West Chester, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State Ferris & Co. 3/19/2012 4 Donation 5 Other (Specify) Pennsylvania ^{22. Name and Address of Facility}
Tarring-Cargo Funeral Home, P
333 S. Parke St, Aberdeen, MD P·A 1D·21001 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ jubdural nematoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to in reduct cause. Enter Underlying Examiner Due to for sells nonsequence of Cause (Disease or injury that initiated events resulting in death) Last EXAMINER ED BY MED Due to (or as a consequence of): physician sthe burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Month Day Pregnant at time of death signed by the at P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nemorrhage Interventniular Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 █ No Subarachnoid 24a Was an page 2 s performed? Yes 2 N certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After th
bletely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No unknown Investigation lu. Fall down stairs 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 420 Don's Cr. Aberdeen, MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier rpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and hitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 12 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St S. Greene Baltimore, MD 31. Date filed (Month, Day, 32. Registrar's Signature State MAR 1 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a, b per doc g925 3-23-12 vt 23e
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ Month 8:12 PM Nachola W. Peeler March 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 1309 Hillcrest Drive Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) r 1 Year If Under 24 Hrs **Funeral** Hours **Director** 1 □ M 2 🛛 F Jan. 31, 1933 Texas 450-42-8768 Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director MD Frederick Frederick 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1309 Hillcrest Drive 21703 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. o. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph M. Miller <u>Wilma Wayne Ray</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trains Katherine Luther/daughter 13801 Lewisdale Rd. Clarksburg, MD 20871 3altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Journey Crematory 03/10/12 Woodbine, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service Beverly L. Heckrotte, P.A. Cl MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between lung cancers Immediate Cause (Final Onset and Death Physician/ Metastatic Melanoma disease or condition Medical resulting in death) **Examiner** Melanoma Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Month Year Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diabets, diabetic macular edema, hypertension 1 ☐ Yes 2 🗷 No Throbably 4 ☐ Unknown chronic bronchitis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\overline{\mathbf{X}}$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Natural 5 Pending n 24 hours and ne Funeral Director: A' Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature 29d. Date signed (Month, Day, Year) DOO 69203 March 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Naja Thomas 7190 Crostwood Blvd Frederick Maryland 21703 laja Thomas State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 17, per fb, g925 3-15-12 sm
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/  $20\overset{\text{Year}}{12}$ MARCH **QUAYTMAN** 10:25A M ROSALIND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE CARE TOWSON if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min Director 129-10-0937 1 M 2 X F 94 03/04/1918 NY Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State notified at Director 1 Yes 2 X No OWINGS MILLS MD BALTIMORE 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? ò ed other than "natural", or items 23a o event, the Medical Examiner must be Completed by Funeral 21117 4730 ATRIUM COURT USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give Specify: 3 X Widowed 4 ☐ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) ADMINISTRATIVE ASSISTANT **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **LANGSMAN** GUSSIE ADOLPH UNKNOWN other traumatic Langsam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a: If item 27 i 19023 HUNT PASS COURT, PARKTON, MD 21120 MILES QUAYTMAN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) MONTEFIORE CEMETERY 03/14/2012 ST. ALBANS, NY 21. Signature of Fune 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Dusito (or de a consequence of) if any, leading to immediate cause. Enter Underlying the burial-transi Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No signed by the atter Month Day Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

1 Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPice မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury 5 Pending work after death. 1 Yes 2 🗌 No Investigation completely filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nly one) gnature 861500Q 405, Ballinere, MD 21204 ress of person who completed cause of death (Item 23a) (Type, Prints Shahlln, 6101 N. Charles S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Year 2012 Physician/ 7 1 05 PM Medical a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALLIMORE If Under 1 Year If Under 24 Hrs. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 🖼 Months Hours 13-03-6138 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No more 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral USA DiKesville 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No 1 Newer Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 ₩Widowed 4 □ Divorced Completed er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Be ____ 17. Fat**yl**er's Name *(First, Middle, Last)* 18. Mother's Name (First, Middle, Maiden Surnar ည THOU mma Page 1 and 2 should ment of Health and Me oformant's Nam<u>e/Relat</u>ionship (*Type, Prij* permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau ac Baltimore, ethod of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemptery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ege Funeral Services an A1133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ TE RENAL FAILURE <u>days</u> Medical resulting in death) Due to (or as a consequence of) Examiner HOUYS Se vientially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical that the death certificate be the P.O. Box 687 as IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) 4 Pregnant a
9 Unknown Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has certificate Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 PNO မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 
Yes Certificate: 28d. Describe how injury occurred After iniury 1 🗷 Natural 5 Pending 2 🗌 No within 24 hours after death. To the Funeral Director: A ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month. Day, Year) MD 0069177 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDV RALTIMORE MOHAMMAD 21229

State Registrar 900

VALIKHANI

32. Registrar's Sign ture

31. Date filed (Month, Day, Year) NAR 15 2012

CATON

AVE

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012 Year Day Physician/ 09 7:47P Frances P. Roeder March Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5320 Dorsey Hall Drive #321 Ellicott City Howard If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 79 1 □ M 2 🖾 F Director 579-38-5658 Pennsylvania Apr. 24,1932 28a-f show 10c. City, Town or Location 10b. County must be notified at Director 1 Yes 2 No Howard Ellicott City MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 by Funeral items 23a 21042 USA 5320 Dorsey Hall Drive #321 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give ō 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School Transportation Bus Driver permit. Page 1 and 2 should be filed will Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the of Health and Mental Hyg item 27 is marked othe other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P Helen Rodgers Francis P. Eckstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3712 3rd Ave. Edgewater, MD 21037 <u>Ernest F. Lanciano / son</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 3/14/12 Woodbine, MD 4 Donation 5 Other (Specify) Signature f neral Service Lic 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Acute Cardiorespiratory Failure Medical resulting in death) Examiner Metastaic Gastroesophageal Cancer Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Chronic Kidney Disease or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the burial Completed by Physician/Medical Chronic Hypertension Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No Dav Year Pregnant at time of death 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pendina Division 1 🗌 Yes 2 🗌 No Accident Investigation after deat 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete 29b. Signature and title of certifig D{3232

Registrar

DHMH 17 Rev 06-2011

State

15245 Shady Grove Rd Suite 130 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Patricia Gomez,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	State of Maryland / Department of Health and Mental Hygiene  State Registrar  Certificate of Death  Reg. No. 2012 08115
Physicia	n/	Registrar  1. Decedent's Name (First, Middle, Last)  RALPH  ROUSTER  2. Page of Death  1. Decedent's Name (First, Middle, Last)  2. Page of Death  1. Decedent's Name (First, Middle, Last)  2. Page of Death  1. Decedent's Name (First, Middle, Last)  2. Page of Death  1. Decedent's Name (First, Middle, Last)
Medic Examin		4a. Facility Name (if not institution, give street and number)  Seasons Hospice  4b. City, Town, or Location of Death  Baltimore  4c. County of Death  Baltimore
Funeral Director		5. Social Security Number 244-28-5522  1 N 2 F 84  1 N 3 F 84  1 N 3 F 84  1 N 4 5 F 84  1 N 5 F 84  1 N 6 Sex  1 N 6 Sex  1 N 7. Age (In yrs. last birthday)  1 Months Days Hours Min. (Month, Day, Year)  1 N 6 Sex  1 N 6 Sex  1 N 7. Age (In yrs. last birthday)  1 N 6 Sex  1 N 7. Age (In yrs. last birthday)  1 N 7 Sex  1 N 8 Days Hours Min. (Month, Day, Year)  1 N 7 Sex  1 N 8 Days Hours Min. (Month, Day, Year)  1 N 7 Sex  1 N 8 Days Hours Min. (Month, Day, Year)  1 N 8 Days Hours Min. (Month, Day, Year)  1 N 8 Days Hours Min. (Month, Day, Year)
yland f show ed at	tor	Usual Residence of Decedent       10a. State     10b. County       MD     N/A       Baltimore     10b. County       10c. City, Town or Location     10c. City Limits       Baltimore     1X Yes 2 $\square$ No
h the Mar a or 28a- be notifie	al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
ours after atural", o cal Exam	eted by	3 Notice of Proceedings of Proceedings of Procedings of Proceedings of Procedings of P
vithin 72 h yiene. er than "n the Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) 10th  (Give kind of work done during most of working life. DO NOT use retired)  Truck Driver  University of Maryland
Janua Abe filed v Aental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Charlie Royster  18. Mother's Name (First, Middle, Maiden Surname) Fannie Hill
Nat yiallo		19a. Informant's Name/Relationship (Type, Print)  Vivian Royster/Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  2416 Hollins Ferry Rd. Balto., MD 21230
Page 1 an rent of He int: If item		20a. Method of Disposition  1 Normalise 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of vermatory or other place)  WOODLAWN 20c. Location - City or Town, State Woodlawn, MD
permit. Page 1 Department of Important: If is any injury or o		21. Signed and Address of Facilit Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223
Physician/		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Onset and Death
Medical Examiner		resulting in death)  Due to (or as a consequency of):
uted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Cause (Disease or injury that initiated events c.
e be exec	ical	resulting in death) Last  Due to (or as a consequence of):  d.
DIVISION OI VICAL RECORDS, F.O. BUX 00/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Date of delivery   Month Day Year
t the death of the atternation o	Physici	in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
aw requires that as been signed as been signed be de	þ	1 Yes 2 No 3 Probably 4 Unknown
The law re ate has be page 2 sh	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 1 Yes 2 No
VILAI hysician: his certific al director,	To Be	25. Was case referred to medical examiner?  1
tending Pleath.  or: After the funera	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be
DIVISION  ital or Attendin  urs after death.  ral Director: Aft illed in by the fu		4 Homicide determined 28e. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Hural Houte Number, City or Town, State)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed Month, Day, Year)
<b>6</b> ≥ <b>6</b> 0		
HV		30. Natine and address of person who completed cause of death (Item 23a) (Type, Print)  Mach Bols 6934 Au Ahm Blod Gley Bakers 24 061  31. Date filed (Month, Day, Year)  32. Justinar's Signature
Sta Registr		MAR 1 5 2012 June S. Jack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:55 AM Bennie March 3012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bay view Care Center Baltimore Baltimore (ity Johns Hopkins Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye Country)
Virginia 1 🛣 M 2 🗆 F 86 Months Min Director 228-22-2157 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Ves 2 No Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8103 Gray Haven Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White WWII 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Millwright Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Knight permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Ben Shiflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Erma Shiflett (Wife) 8103 Gray Haven Road Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 3/15/2012 Oak Lawn Cemetery 4 □ Donation 5 K Other (Specify) Entombment 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. CORC 7922 Wise Ave. Dundalk Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Dementia 10 Years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown s been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Tyes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred **→**Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Tertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0051185 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Bayvien Circle, Baltimore, Maryland 21224 College Chastmas MD 31. Date filed (Month, Day, Year) **MAR 1** 5 2012 State Registrar

DHMH 17 Rev 7/2009

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		for State Registrar		Giale 0	i iviai yiai		ertificate			liid ivi	entarry	Reg. No	0	0.1	2	η Ω Ι	1
Physicia	ın/	Decedent's Name (First,	Middle, La	st)			•				2. Date of De		- <del></del>	Vear	3.	Time of Dea	ıth
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Examin	ier	4a. Facility Name (if not inst 830 West 4				19	4b. City,		Location of Ltimor			40	. Count	ty of Deat	h		
Funeral		5. Social Security Number	6. 5	ex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2	4 Hrs.	8. Date of Bir	th		9. Birt	hplace	(State or For	reign
Director		214-30-370	0	□ M 2 💢 F	7	78 Yrs.	Months	Days	Hours	Min.	$0ct \frac{Month, Da}{10}$	19:	33	Mar	yla	nd	
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permir Depar Impor any ir		21. Signature of Funeral Se	rvice Licen:	Thomas	s Grego	or	Semat	i Addres	Socie	ty (	of Mary Baltin	land	l, "Į	nc,	nd '	21228	
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Physician/		Immediate Cause (Final disease or condition			artar	1 Ca	nee	_								et and Death	
Medical Examiner		resulting in death)		Due to (d	or as a conseq											7	
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e deat the at thed fo	Physician/Medical	1 Yes 2 No		4 🔲 Pregn 9 🔲 Unkno	ant at time of own	death 5	Other (sp	ecify)					M	lonth	Day	Year	
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iysicia is cert direct	To Be	examiner? 1  Yes 2 No		Hospital:	npatient 2 🗆	ER/Outpatie	ent 3 🗆 DC	Othe	r:		ne 5 Resi	dence 6	Otl	her (Speci	fv)		
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To the within To the comple	Σ	only one) 3 L Cert 29b. Signature and title of c		se Practioner: T	o the best of m	y knowledge,	_	red at the License		and place	, and due to th			nanner as s ed (Month		ear)	
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25		30. Name and address of pe	Λ	completed cause	of death (Item	23a) (Type,	Print)	الله ه	B	140	14	MO	-	423	1		
Stat	e	31. Date filed (Month, Day, Y	(ear)	nstrag OD. Re	e of death (Item 1650 ( gistrar's Signa	ture		(4)	100	LITY	nort.	1110		~[# 0	1		
Registra	ar	MAR 15	2012	ann	U p.	19											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19a-b, per fh, g925 3-15-12 sm State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day 12:30 AM George Stephen Smith Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Manor Care Dulaney Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, pr. 27 Hours Min Days Country, 186-12-2349 **Director** 1 🕅 M 2 🗆 F 87 1924 Yrs. Apr. Usual Residence of Decedent 28a-f show 10d. Inside City Limits notified at 10a. State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2x No Reisterstown MD Baltimore 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21136 USA 429 Cockeys Mill Rd. items within 72 hours after death i Deceaei...
ied Forces?

yes 2 No

ive '43-'46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. ö 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates þ Maryland 21215-0036 1 Yes 2 No Specify Specify: white 'natural", 3 🗌 Widowed 4 💢 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Drug Rehab. Counselor Health Care n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P permit. Page 1 and 2 should be.
Department of Health and Mental
Important: I frem 27 is meany injury or othe-ပ Mabel Mosley George Smith 19a. Informant's Name/Relationship (Type Print) **Deborah L. Norris/Daughter** <del>George Smith</del> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel Mosley 429 Cockeys Mill Rd. Reisterstown, MD, 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/14/12 Atlantic Crematory Glen Burnie, MD 21. Signature of F 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael 23a. Pari 1. Enter the disease of shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ le mentia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Mellitus ia betcs Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ha and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Month Year Pregnant at time of death Unknown signed by the at d be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 2 No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospita Other: 4 XNursing Home 5 A Residence 6 A Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: I or Attending F after death. injury 1 😾 Natural 5 Pending work: 1 Yes 2 🗌 No filled in by the Accident Suicide Investigation **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month, Day, Year)

yrus Asadi,

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1012

State Registrar Fallscraft Way

H0054424

3-12-12

LuTherville, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 ()

Amend Items 23a per dr.,g925,03/15/2012dhb

Certificate of Death

Reg. No. For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ MARCH 35 6:58 A.M ROBERT LOUIS SIMMS. SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NOTTINGHAM 82 LAUREL PATH COURT 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Numbe 7. Age (In yrs. last birthday, **Funeral** Month, Day, Yea /16/1947 1 XM 2 □ F Months Days Hours MARYLAND 217-50-1142 64 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No NOTTINGHAM MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 82 LAUREL PATH COURT 21236 or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?.

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: I Hygiene. other than "natural", If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) BUDGET MANAGER STATE OF MARYLAND YEARS Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of ပ permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked JAMES SIMMS IMOGENE BENNETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NOTTINGHAM, MD LAURA L. SIMMS/WIFE 82 LAUREL PATH COURT 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) ST. STANISLAUS CEM. 3/12/2012 BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Signature of Funeral Service Licensee MOO217 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Myocardial Infarction** Approximate Interval Between Myocardial Infarction onstand Person Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Examine it any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be as the t IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Box ( Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work' 1 Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifier 2012 address of person who e of death (Item 23a) (Type, Print) aziner Month, Day, Year) NAR 15 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

23a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Susan Margaret Schultz March 9 0217 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10236 Owen Brown Road Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday, **Funeral** Min Days Hours **Director** 475-64-6104 1 🗆 M 2 🔀 F 59 4/12/52 Washington Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified Columbia 1 Yes 2 X No MD Howard ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe ms 23a o Funeral with USA 10236 Owen Brown Road 21044 items within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0. 1 Never Married 2 X Married þ 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyWhite "natural" 3 Widowed 4 Divorced Year or Dates 1975 – 2007 Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ Musician Army Field Band Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental I 27 is marked of traumatic eve ၉ Clarence Myron Schultz Margaret May Hodgson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Patrick Dillon / husband 10236 Owen Brown Rd Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 🔀 Cremation 3 D Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 3/13/12 Woodbine, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service, Beverly L. Heckrotte, P.A. Cl P.O. Box 784 Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Glioblastoma Medical Due to (or as a consequence of Examiner Astrocytoma Sequentially list conditions Examine if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy perform Yes 2 X No 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on title of certifier 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 3/9/12 D20678 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD WRNMMC 8901 Rockville Pike Bldg#19 Bethesda, MD 20889 Edwarda M. Buda,

W DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

# Decease Name: William H. Shrimp DOD: 02/20/2012

**VOID:** 

2012 8121

SEE

Replacement: 2012 6979

3/22/12dM

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State C	n iviai yiai		tificate of l	neaith and it Death	,	Reg. No. 2	2 08122
	Physicia	n/	Decedent's Name (First, M		•				2. Date of De Month		3. Time of Death
Н	Medio Examin	al	CYNTHIA  4a. Facility Name (if not institu	tion, give street and num	nberl	SINGER		r Location of Death	MARCH	13 2012 4c. County of E	
-	Examili	er	4317 CRESTHE	_	112017		BALTIM(			BALTIM	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir		
	Director		218-40-4916 Usual Residence of Decedent			69 Yrs.			117/20	7/1942	Birthplace (State or Foreign Country) MD
	and show	tor	10a. State 10b. Con		10c. Cit	y, Town or Lo	ation				10d. Inside City Limits
	Maryl 28a-f otifie	irect	MD B.	ALTIMORE	В.	ALTIMO	RE				1 ☐ Yes 2X No
	th the	al D	10e. Street and Number		-		10f. Zip Code			10g. Citizen of What	Country?
	ath wi	Funeral Director	4317 CRESTHE		edent Ever in U.S	2 13 1	21215	linnania Origin? (Spe	ocifu Voc or No	14.5	USA
9	er de	by F	1 ☐ Never Married 2 🛣	Armed Fo 1 ☐ Yes	orces? 2 X No			lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed by	3 Widowed 4 Divo	rced If Yes, Giv Year or Da	/e	1	☐ Yes 2 No	Specify:		Specify: W	HITE
15	72 ho n "nat fedica	nple	15. Dec (Specify only I	edent's Education nighest grade completed)	)	(Give I		during most of worki	ing	16b. Kind of Busine	ess Industry
212	vithin jiene. er thai		Elementary/Seconday (0-	12) College (1	-4 or 5+)		NOT use retired) EDICAL SI			CLE	ERICAL
	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	Be	17. Father's Name (First, Midd	tle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surname)	
yla	uld be Ment narke	얼	BERNARD			SOPHER		GERTRUI	DE	DC	ORTCH
Maryland	2 shot th and 27 is n traum		19a. Informant's Name/Relati			4.5	- :			r, City or Town, State,	
	1 and 2 s of Health item 27 i		GARY SINGER  20a. Method of Disposition	/ HUSBAND	20b. F	Place of Dispos	sition (Name of		Date	TIMORE, MI 20c. Location - City	
m	Page 1 nent of ant: If it		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		State M	OSES M	atory or other place ONTEFIOR HEBREW	E- 03/	13/2012	•	,
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Serv	co Lic ee		22	Name and Addre	ss of Facility SOI	L LEVIN	SON & BROS	
			23a. Part 1. Enter the disease	e, or complications that o	caused the deat						Approximate
	Ph,sician/	g 5	Immediate Cause (Final disease or condition		vaclan	and	cp_				Interval Between Onset and Death
San Contract	Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):	- ( ) 0 1				
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	5		,					
	execu an and rial-tra		that initiated events resulting in death) Last	Due to (	(or as a consequ	uence of):					
3760	cate be executed physician and the burial-transit	<b>Nedical</b>		d							
687	ath certific attending p I for use as	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	ncy				20d D-t	4-15
Box	eath c e atter d for u	Physician/N	in the past 12 months?  1 Yes 2 No	1 Live 4 Preg	Birth 2 Teta nant at time of c	al death 3 🗌	Ectopic pregnand Other (specify)	cy		23d. Date of Month	Day Year
P.O. E	that the des	Phys	9 LJ Unknown	g 🗌 Unkr							
<b>Q</b> .	res tha signed	ρ	Part II. Other significant con	ditions contributing to d	leath but not res	ulting in the ur	iderlying cause giv	ven in Part I.		/	e to the cause of death?
of Vital Records,	v require been si should	Completed				<u>-</u> -			1 🗌		
ecc	The law ate has page 2 s	duc							autor perfo	prior rmed? prior death	
al H	ician: The certificate ector, pag	Be C	25. Was case referred to med	ical			26. PI	ace of Death (Check	1  Yes	2 No 1 L	Yes 2 No
Z:	hysician: this certific al director,	20	examiner? 1 🗆 Yes 2 No		Inpatient 2 🗌	ER/Outpatien	3 DOA Othe	er: 4  Nursing Ho	me 5X Resid	lence 6  Other (St	pecify)
n of	ding Pł h. After th funeral	ate:	27. Manner of Death  1 Natural 5 □ Pe	inding .	of injury th, Day, Year)	28b. Time of injury	28c. Injun work	?	28d. Describe h	ow injury occurred	
Siol	Attendii r death. ctor: Ai y the fu	Certificate:	3 Suicide 6 Co	restigation ould not be termined 28e. Place	of Injury - At ho	me. farm. stre	M 1 L et, factory, office	Yes 2 □ No	28f Location (S	Street and Number or	Rural Route Number
Division	tal or safter safter al Dire		4 - Homiciae ae	buildir.	ng, etc. (Specify	)	,,,		City or Tow		nara riodic Namoci,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 L Medic	ying Physician: To the b cal Examiner: On the bas ying Nurse Practioner:	sis of examination	n and/or investi	gation, in my opinio	on, death occurred at	the time, date a	nd place, and due to the	ne cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of der				29c. License			29d. Date signed (Mo	-
				Sull			Deer	9054		3 13 13	
1	21		30. Name and address of pers	on who completed caus	se of death (Item	23a) (Type, P	Breibur1	, M . D.	2178	,	
	Stat Registra	_	31. Date filed (Month, Day, Yea MAR 15		egistrar's Signat	back					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 MARCH SCHROEDER 04:00A M SYLVTA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OAK CREST VILLAGE PARKVILLE BALTIMORE 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Davs Min. Hours Director 217-05-7804 1 🗆 M 2 🗓 F 90 11/19/1921 MD Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE PARKVILLE 5 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 23a **Examiner must** 8832 WALTHER BLVD., #319 21234 items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🗶 No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ( If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygelen. Important, if item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ LOUIS HOFFENBERG **EVA** FRIED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL SCHROEDER / SON 1707 GRAFTON RIDGE COURT, FOREST HILL, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ANSHE EMUNAH AITZ CHAIM 03/14/2012 4 Donation 5 Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 approximate Interval Between Onset and Death 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cancer disease or condition resulting in death) Medical Due to (or +s a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atter should be detached for u in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPO / Emphy sema, CAD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 Yes 2 No Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year, /12/12 R171944 CRIP, MIN

Registrar

DHMH 17 Rev 06-201

State

8800 Walther Blod, Packville MO 21234

ompleted cause of death (Item 23a) (Type, Print)

	State Registrar	and the second			(	Certificate of I	Death	Г	Reg. No	.2012	0812
n/ al	1. Decedent's Name	e (First, Middle, Li	ast)			SHELYUBSI	ζY	2. Date of De MARCH		20 Y2	3. Time of Death 08:30P
er	, i		e street and number)				r Location of Death		40	c. County of Death	
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Director	10a. State	10b. County	11077			or Location					10d. Inside City Limi
e C	MD 10e, Street and Nun	BALTI	MORE	BA	LTI	10RE 10f. Zip Code			10a C	itizen of What Cour	
erai	0 1 ST T	EE COURT				21209	·		rog. o	THE COURT	USA
Funeral	11. Marital Status	EE COURT	12. Was Decedent	Ever in U.S	3.	13. Was Decedent of F		cify Yes or No-		14. Race - Americ	can Indian,
2		ied 2 🛚 Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give	No		1 Yes 2 No		nicari, etc.)		Black, White, Specify:	etc.
ופ	3 Widowed	4 ☐ Divorced  15. Decedent's	Year or Dates.		10- 5					MHT	
Completed		cify only highest of	rade completed)		(0	Decedent's Usual Occup Give kind of work done fe. DO NOT use retired)	during most of worki	ing	16b. k	Kind of Business In	dustry
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ם כ	17. Father's Name (i	First, Middle, Last	)				18. Mother's Name	e (First, Middle,	<i>Maid</i> en	Surname)	
2	LEV			2	SHEL	YUBSKY	MARINA			GERCH	ONOVA
	19a. Informant's Na	me/Relationship				Mailing Address (Street					Code)
	SVETLAN. 20a. Method of Disp	A MELAME	D / WIFE	T 001 F	_	9 1ST TEE C	1				
	1 🕅 Burial 2	Cremation 3	Removal from State	С	emetery,	Disposition (Name of crematory or other place	ce) :	Date		ocation - City or To	
	4 ☐ Donation  21. Signature of Fo	5 Other (Spec		В.	ALTL	MORE HEBRE		3/2012		REISTERST	
	21. Signaturi or F6	rerai service Lice	isee				STERSTOWN				-
	23a. Part 1. Enter t	le disease, or co	nplications that cause	d the deat	h. Do no	t enter the mode of dyir					Approximate
	Immediate Cause (	Final	one cause on each line		0	ancreas co					Interval Between Onset and Death
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0	25. Was case referred examiner?	No Medical	Hospital:			Oth	lace of Death (Checker:	. /			
2	27. Manner of Death	<del></del>	1 ∐ Inpati 28a. Date of inju		ER/Outp 28b. Tir	atient 3 L DOA	4 L Nursing Ho	me 5 Resid		6 ☐ Other (Specify rv occurred	)
Car	1 Natural 2 Accident	5 Pending Investigati	(Month, Da	y, Year)	inji	ury work	⟨?  Yes 2 □ No	Edd. Describe i	iow injui	y occurred	
Certificate:	3 Suicide 4 Homicide	6 Could not determine	be 28e. Place of Inju	ury - At ho	me, farn	n, street, factory, office				nd Number or Rura	Route Number,
			building, et	c. (Specify	"			City or Tow	vn, State	9)	
Medical	29a. Certifier 1 (Check 2	Certifying Ph Medical Exar	ysician: To the best of niner: On the basis of e	my knowl	ledge, de	eath occured at the time nvestigation, in my opini	e, date and place, an	d due to the ca	use(s) a	nd manner as state	ed. use(s) and manner s
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		State Registrar				Ce	ertificate of L	Death		Reg. No	2017	2 08 25
Physicia	n/	Decedent's Nam-		,					2. Date of De Month	Da		3. Time of Death
Medic	al	4a Facility Name /if		obert	Joseph	1 Tro	mbetta	r Location of Death	March		2012	9:31 PM
Examin	er	The Dove		give street and numbe	7		Westmi			40.	Carro1	
Funeral		5. Social Security N		6. Sex 7.	Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		9. Birt	hplace (State or Foreign
Director		216-36-		1 <b>X</b> ] M 2 □ F	70	Yrs.	Months Days	Hours Min.	(Month, Da Aug. 2			intry)
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anylar sa-f s ified	ectc	MD	Co	arroll				Usatmina	<b>.</b>			1 ☐ Yes 2 🙀 No
the N or 28	٥	10e. Street and Nur		ITIOTI			10f. Zip Code	Westmins	ter	10g. Cit	tizen of What Co	untry?
s 23a	Funeral Director	39 W€	est Deep	Run Road			21158	3		Un	ited St	ates
death item	Fur	11. Marital Status		12. Was Deceder Armed Force	s?	S. 13.	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White	
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o a m c	Щ	DY	regon	E. Ken	<u>y</u>		/922 Wise	Ave. Dur	ndalk. I	Mary	land 2	1222
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ding F h. After funer	Certificate:	1 Natural	5 Pending		Day, Year)	28b. Time of injury	work		28d. Describe h	iow injury	y occurred	
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the H hin 24 the F nplete		only one) 3	Certifying N	lurse Practitioner: To			e, death occurred at t	the time, date and pla	ace, and due to t	he cause	(s) and manner as	s stated.
<b>10</b> wit		29b. Signature and	4 //	wit, m.	•		29c. License	e number		29d. Dat	te signed (Month)	
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21		Howar	d Pai	o At Z, M.D	death (Item	120d) (Type,	as hing to	4 Rd. 1	te-20	4	Wast mi	21157 48ter, md
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Registra	r	MAD 1	DZUIZ	Leven	1. 1	-						

State of Maryland / Department of Health and Mental Hygiene 4

for State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Jean Jermsta Vivino March 0825 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Walkersville Frederick 10317 Harp Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Director 577-40-9177 1 M 2 X F 93 6/18/18 Minnesota Usual Residence of Dece 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Walkersville 1 🗆 Yes 2 🏝 No MD Frederick 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? ms 23a (must be Funeral 21793 10317 Harp Road USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🛮 Widowed 4 🗆 Divorced Specify: white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Doctor Healthcare 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hazel Edith Graves Loring Jermsta 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean-Marie Vivino / daughter 66 Landers St. San Francisco, CA 94114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 permit. Page 1
Department of I
Important: If it
any injury or or 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 3/13/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses | 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 | Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Ph sician/ Stroke Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician /Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ğ in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown detac signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? this certificate Yes 2 X No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🔀 No Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) ٥ D41619 March 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 63 Thomas Johnson Drive Frederick, MD 21702 Michael Lenner, 31. Date filed (Month, Day, Year) State MAR 1 5 201 Registrar

DHMH 17 Rev 06-2011

amend #9PleaseType or Print in Black Indelibledake Eneuro All Conjectors 19919/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Î 2 March 4:00 Hozzie Williams AKA Hosie Pete Williams Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Sept  $10^{(Month,Day,Year)}$ 919 Countryunk Director 579-38-0292 1 🛣 M 2 🗆 F 92 SC Usual Residence of Decedent show 10c. Citwown or Location 10a. State 10b. County 10d. Inside City Limits notified at Director 28a-f 1 XXes 2 No Hyattsville MD-Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 20011 5 Rock Creek Church Rd.NW by Funeral 23a USA 20783 er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married- 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 **Black** 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Liaison unk event, Be 17. Father's Name (First, Middle, Last) .- unk 18. Mother's Name (First, Middle, Maiden Surname) unk မ of Health and Mental item 27 is marked reduced to other traumatic e Bessie Richenbacker James Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Gladney - grandson Belleville, NJ 07109 21 Lincoln Terrance Department of Healt Important: If item 2 any injury or other once. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1  $\square$  Burial 2  $\nearrow$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\boxtimes$  Other (Specify)  $\verb"in"$  State remeter, crematory or other place)
Final Journey Crematory 03/14/12 Woodbine, MD 21. Signature of Funeral Service Licensee
Ronald S. Wade, Directo
Beverly L. Heckrotte M1251 22 Going Allone Cremation Service P.O. Box 784 655 W. Baltimore St; Baltimore 210201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SEPTICEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** GUMONIA Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? has performed 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 🗌 Yes ္ဝ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 X Natural s after death. Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 46529 IVM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENBELT 7325A HOREVER FARKUAY ONYGIAKA 31. Date filed (Month, Day, Year)
NAR 15 State Registrar

DHMH 17 Rev 06-2011

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	<i>M</i> arylan		artment					2010	00100
			Registrar  1. Decedent's Name (First, Middle	le Last)		Cer	lilicate	Deali	1	2. Date of De	Reg. No.	<u> </u>	U0120
	Physicia		Richard Acton	· · ·	Sr					Month	Day	Year 2012	3. Time of Death
Y	Medic Examir		4a. Facility Name (if not institution				4b. City, Tov	vn, or Location	on of Death	March		County of Death	10040
			Holy Cross Hos	spital			Silv	er Spr	ing		Mon	tgomer	7
	Funeral		5. Social Security Number		ige (In yrs. la	ast birthday)	If Under 1 Months I	Year If Und	der 24 Hrs. s Min.	8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		076-18-8909 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	89	Yrs.				Mar.22			York
	and shov	ĕ	10a. State 10b. County	,	10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mary 28a-f otifie	Director	MD Monto	gomery	Kei	nsingt	on						1 ☐ Yes 2X No
	h the		10e. Street and Number		104		10f. Zip Co					en of What Cou	intry?
	th wit	Funeral	10225 Frederic			Link		0895			US		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Ma		? □ No		Vas Decedent f Yes, specify	Cuban, Mexi	can, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Amer Black, White pecify.Whit</li> </ol>	etc.
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<u>S</u>	uld be d Men narke natic	-	Elvin David W			_			_	Keene			
Ma	2 sho th and 27 is u		19a. Informant's Name/Relations			1				al Route Numbe	-		
ē,	I and I Heal		David Williams  20a. Method of Disposition		20b. P		sition (Name of			Pooles		ation - City or T	,
mo	age lent of nt: If in ry or		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other 6		te   ce Fina	emetery, cren 1 Jour	natory or othe ney Cr	r place) emator	i	- 1		oine, M	
Baltimore, Maryland 21215-0036	permit. F Departr Importa any inju once,		21. Signature of Juneral Service		' M01	651 GG	Name and A	ddress of Fac	:- ematic	on Servi	ce P.	O. Box	784 e, MD 21029
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P.O.	at the	Phy	9 Unknown  Part II. Other significant condition			ulting in the u	ndorking only	o givon in Da	het I				
ds, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	ed by	Tartii. Other significant conditi	ons contributing to death	Dut not rest	arting in the d	nderlying caus	Se given in Fa	art 1.				he cause of death?  bably 4 K Unknown
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Ž	Physician: T r this certifica eral director, p	<u>ا</u> ي	1 Yes 2 XNo 27. Manner of Death	1 X Inpa 28a. Date of In		ER/Outpatien 28b. Time of				ome 5 Resid			y)
n 0	al or Attending Pt s after death. Il Director, After th ed in by the funeral	Certificate:	1 X Natural 5 Pendii 2 Accident Investi	ng (Month, D		injury	- 1	Injury at work? 1  Yes 2	- 1	28d. Describe h	ow injury o	ccurred	
isio	Atten	ij.	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In						28f. Location (S	treet and N	lumber or Rura	I Route Number,
Division of Vital Records,	tal or s afte al Dire		4 El Homidae determ	building, e	tc. (Specify)					City or Tow	n, State)		
	To the Hospital o within 24 hours af To the Funeral Di completely filled in	Medical	29a. Certifier 1 X Certifying (Check 2 Medical I	Physician: To the best of Examiner: On the basis of	of my knowle	edge, death o	ccurred at the	time, date a	nd place, a	nd due to the ca	use(s) and	manner as sta	ted.
	the Ithin 2 the Ithin 2 the Ithe Ithe Ithe Ithe Ithe Ithe Ithe	Me	only one) 3 L Certifying	Nurse Practitioner: To t	he best of m	y knowledge,	death occurre	d at the time,	date and pla	ace, and due to the	ne cause(s)	and manner as	stated.
	<b>7.≥6</b> 8		29b. Signature and title of certifie	Do mit	)			cense numbe			29a. Date s	signed (Month,	uay, year)
	'		30. Name and address of person	Who completed cause of	death (Itom	23a) /Tuno D		ا ساس	-00	2		-19/1	
41			Dr. Kanwaljit		,	, , , , ,	,	Dr Ci	lver	Spring,	ML J	0010	
	Stat	.6	31. Date filed (Month, Day, Year)	32. Pegist	rar's Signatu	ire		<i>D</i> E	TACT	oprang,	<u> </u>	W21U	
	Registra	ir	MAR 1	5 2012   Den	in p	9. 400	uke						

HMH 17 Rev 06-2011

12-02056 Darlene White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 08129 1. For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 11, 2012 **Medical Examiner** Darlene Lynn White 1535 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1403 Pleasant Valley Road, Apt 1 Westminster 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** If Under 24Hrs. 50 Months Director Davs Hours Min Dec 9 1961 217-64-6438 1 M 2 X F Country) Yrs Usual Residence of Deceden ij 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Carroll Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic eveot, the Medical Examiner must be notified at once. Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1403 Pleasant Valley Rd. 21158 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: white δ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) domestic 12 homemaker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) David Lee Winegar Shirley Matthes 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Winegar (mother) 2013 Rudy Serra Dr., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Loudon Park Cem. 3-16-12 Baltimore, MD 4 Donation 5 Other Specify. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel M60764 P.O. Box 195 Sykesville, MD 21784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Combined drug (Methadone, Olanzapine, Citalopram) Intoxication £xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to for as a consequence or if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical attending physician or use as the burial -X UNPENDED ☐ AMENDED 23a, 27, 28a-f, per me, g925 3-29-12 sm Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown signed by the a Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? After this certificate ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural death. Director: d in by the f 1 Yes 2 X No unknown 3-11-12 2 ___ Accident fd 3:30 pm Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, Ci or Town, State) 1403 Pleasant Valley Rd. Apt 1 Westminster, MD. 3 Suicide 6 X Could not be determined (Specify) Residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated Medical 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BOME O.C.M.E. March 12, 2012 Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) er's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2010 <u>Bonnie</u> Jean Whitacre Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany <u>Western Maryland Health System</u> Cumberland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) **Director** 218-50-0609 1 🗌 M 2 🔀 F Maryland 01/13/1947 65 Usual Residence of Decede 10d. Inside City Limits 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. **Funeral Director** 1 Yes 2 K No Bedford Bedford PA 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 15522 U.S.A. 112 Wilhelm Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black White, etc. Armed Force ģ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Office Cleaner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Freida Potts Shrout Everett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 112 Wilhelm Drive, Bedford, PA 15522 Larry Whitacre / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 103/14/2012 | Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signatur of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MARKY disease or condition resulting in death) Due to (or as a consequence of): Medical **Examiner** Sequentially list conditions Examiner if any leading to in medial cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months Month Day Year Pregnant at time of death Yes 2 No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 🗌 Yes Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Division of Vital completely filled in by the funeral director, Be 25. Was case referred to medical xaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 Inpatient 2 A/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury work? Natural 5 Pending 2 No Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the

State Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year,

voo completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Esther Atkins 03 6:14 A Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Citizens Care Center Havre de Harford Social Security Number If Under 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🔀 Hours 579-24-5594 Virginia Yrs 03/4/1916 Director Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified Harford MD Belair 1X Yes 2 No 10e. Street and Number o 10f. Zip Code ms 23a or must be i 10g. Citizen of What Country? by Funeral 410 E. MacPhail Road 21014 USA Page 1 and 2 should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. "natural" Completed 3 ₩ Widowed 4 □ Divorced Specify: Black Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 4th College (1-4 or 5+) and Mental Hygiene. event, the Caregiver Private other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Edmund Layne Eliza Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Gail Coates (niece) 516 Missouri Avenue NW, Washington DC 20011 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, injury o 4 Donation 5 Other (Specify) Ardent Cremation Sv. 3/19/2012 Hanover, MD of Funeral Service 22. Name and Address of Facility Latimore Funeral Services, 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cenvosilono Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No jō Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law it thin 24 hours after death.

The Euneral Director, After this certificate has the property of the funeral director, page 2 simpleted filled in by the funeral director, page 2 simpleted filled in by the funeral director, page 2 simpleted filled in by the funeral director, page 2 simpleted filled in by the funeral director. autopsy perform death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Ma er of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the could find the country of the time, date and place, and due to the cause(s) and manner stated. nlu n dat the time date and place, and due to t within To the 29b. Signature and title of certifie P 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Print)

30. Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar

31. Date filed (Month, Day, Year)

6

Wesley	Morgan	Armstrong
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		1- For State Registrar		Certifi	cate of	Death			R	eg. No	<b>)</b> .		
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		4a. Facility Name (if not institution, g			14	b. City, Town,		of Death	iviaich 9, /	4	c. County o		
		Meritus Medical Center  5. Social Security Number 6.	Sex 7. Age	/l=		Hagerstov					Washing		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho injury or other traumatic event, the Medical Examiner must be notified at once	ł	4 Donation 5 Other Specif 21. Signature of Funeral Service Lice	ry:	nera		me and Addres			ose Fu	_		_	
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Physician /Medical		failure. List only one cause on e	each line.							est, she	ock, or hea	rt 🎽	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Atheroscle: Due to (or as a consequ	rotic uence of):	Cardi	ovascul	ar Di	sease	<u> </u>	_		_	Death
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Box 687 death certific the attending	Sicial	past 12 months?	1 Live birth 4 Pregnant at tim			I death 3 er (Specify)	Ectopio	c pregnanc	y	1	Month	Da	y Year
J. Bo; the death by the att	Physician	1 Yes 2 No 9 Unknow  Part II. Other significant conditions	9 Olikilowii	ut not recultin	a in the un	doctrine excess	sives is De		Logo Did to				e cause of death?
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Physic Physic er this ral dire	٥,	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient  28a. Date of Injury	2 🗸 ER/O	utpatient Time of Inju		Other at Work		lome 5 F				
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	Certification:	2 Accident Investigat 3 Suicide 6 Could not	28e Place of Injury	/ - At home, f	arm, street,	factory, office I	ouilding, etc	c. 28			nd Number	or Rura	Route Number, City
Divis	5	4 Homicide determine 29a. Certifier 1 Certifular Physics	(Opodiny)						or Town, St				
Divis  To the Hospital or Al within 24 hours after a for the Funeral Direct completely filled in by	<u>رة</u> ا	(Check only   Oertifying Fifyard	clan: To the best of my kr r:On the basis of examin	nowledge, de ation and/or i	ath occurre nvestigatio	d at the time, d n, in my opinior	ate and pla n, death occ	ice, and du curred at th	e to the cause e time, date a	e(s) and and pla	d manner a	s stated e to the o	cause(s)
S W S	Š	29b. Signature and title of certifier	and manner stated.			29c. Licens	se number			29d. [	Date signed	(Month	n, Day, Year)
		In	N. 14			O.C.	M.E.			Mar	ch 10, 20	012	
k pend	1	30. Name and address of person who Jack Titus MD. Deputy	completed cause of deat Chief Medical Exa	,	10 W/ Pr	altimoro Str	net Ralti	more AA	D 21222				
Sta	te E	31. Date filed (Month, Day, Year)	32. Resistar's		m. may b	and the same of	ct, Daill	more, M	U Z 1223				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Day John E. Baucom **2**012 12:39PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Baltimore-Washington Medical Center 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month 1902)1945 County aryland 66 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Xyes 2 □ No MD Severn Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 7822 Telegraph Road 21144 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian rmed Force Yes 2 Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify Specify Completed 3 Divorced 4 Divorced White Year or Dates. NOVY Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) Postal Service Employee Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked ot မ Carolyn John Baucom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or Advantant in the man in the man injury or Advantant in the man injury or Advantant Erica Bates Fuchs / Friend 4014 Marigold Drive, Ames, IA 50014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 3/14/2012 Beltsville, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall` Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
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1 ☐ Yes 2 ☐ No ō Day Other (specify) Month Year Pregnant at time of death the detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 Yes 2 No Director: After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 Anpatient 2 🗆 ဂ္ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred iniun 5 Pending Natural 1 Yes 2 No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29c. License number **D68246** 29b. Signature and title of certifie Hospital Drive, Gla Burnie, MD 21061 adim

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, I

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ean MATITCH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death HOSPITAL SUMOS HOPKINS +. Morc If Under If Under 24 Hrs. **Funeral** al Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 219-94-4999 (Month, Day, Year) 3/13/1966 Country) **Director** 1 🙀 M 2 🗆 F 46 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Manchester MD Carroll 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21102 **USA** 3213 Keating Court Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Narried "natural", or 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Reliable Churchill is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Distributors 4 sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leroy Bass Shirley Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important. If item 27 is
any injury or other trau 3213 Keating Court, Manchester, MD 21102 Lisa Bass, wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Carroll Cremation 3/16/2012 Hampstead, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 Lemne 934 S. Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ enKem disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine que to for es e consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the as igned by the attending be detached for use as IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? Division of Vital the funeral director, 26. Place of Death (Check only one) Hospital 2**X** No Other: မ 1 🗌 Yes 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending (Month, Day, Year) work? injury 24 hours after death. Funeral Director; At 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29c. License number 30. Name and address of person who completed cause of death-(frem 23a) (Type, Print) Wolfe St. Baltimore, MD 2128 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month **Physician** 16:30 PM llarie benneu 4,2012 March /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 54 214-78-8395 Director MAY 25,1957 MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 😿 No Director MD HARFORD BEL AIR 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5 23a 1311 SCOTTSDALE DRIVE UNIT P 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc an "natural", or ite Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ∐ Yes 2 📈 No WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " College (1-4 or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. 12 CIVIL SERVANT FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTHONY G. RAPISARDA MILDRED D. SODARO ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE MELVIN W. BENNEY, JR. 1311 SCOTTSDALE DRIVE BEL AIR, MD. 21015 item 2 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State ₽ Department of Important: If it any Injury or o 1 X Burial 2 Cremation 3 Removal from State QUANTICO NATIONAL CEM. 3-21-2012 TRIANGLE. VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySCHIMUNEK FUNERAL HOME OF BEL AIR 21. Signature of Funeral Service Licensee 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate erval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) subdurg dau /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, EXAMINER Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury CERTIFICATION APPROVED BY ME The law requires that the death certificate be executed that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) d by the al 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕍 nknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes No 1 🗌 Yes 2 **7**No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day Year) Fe h Z8 2012 funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accident back against death. 1500 PM 1 🗌 Yes 2 X No tell the 1 after death 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num er or Rural Route Number, filled in by determined 4 - Homicide 13 if or Town, Speed ale Dr Bel Air, 10 2101 tome 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number MD RES-000 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV Anthony
31. Date filed (Month, Day, Year) trat talone 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature State 8 201 Registrar

DHMH 17 Rev 1/2001 11595 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 08136

		1- For State Registrar		Certifica	ate of	Death		,,	Reg	ــــ g. No.	UIL	. 0010
Physicia dical Exami	an/	Decedent's Name (First, Middle,Last	William		tz, S	Sr.			Date of Death	Day '	Year	3. Time of Death 2042 hrs
		4a. Facility Name (if not institution, given 296 Mountain Rid 296 Mountain Ridge Court	ge Court Ap	ot A	4	b. City, Town, o Glen Burni		of Death			nty of Death Arundel	
Funeral Director				n yrs. last birt	hday) Yrs.	If Under 1 Year Months Day				9/1943	Eorgia	hplace (State or n untry)Mary1and
Maryland <b>28a-f show any</b> d at once.	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne A:  10e. Street and Number	ŀ	c. City, Town		urnie			- 160	g. Citizen of	NATh at Cause	10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	296 Mountain Ri	dge Court A	Apt. A		210				_	S.A.	ury?
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify or	12. Was Decedent Everage Armed Forces?  1 Yes 2 X  If Yes, Give Year or Dates:	No	If Ye	Decedent of His, specify Cuba  Yes 2 X No	n, Mexican, s specify:	Puerto Ric	an, etc.)		hite, etc. fy: W]	can Indian, Black,
1/215-0036 d be filed within 72 hours after fental Hygiene. narked nither than "natural", event, the Medical Examiner.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	<del></del>	during mo	st of working life	e. DO NOT i	use retired)		Wes	tingh	·
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and 2 should fealth and Mitem 27 is muttraumatic c	2	19a. Informant's Name/Relationship (Tywilliam Butz, J		] 1	1404		Landi	ng Ro	ad Mo	nkton	, Mar	yland 21111
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2		20a. Method of Disposition  1 X Burial 2 Cremation 3  4 Donation 5 Other Specify:	_ (	cremate	ory or oth Hil	1 Cemet	ery	03/1	5/2012		imore,	Maryland
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Physician Ivedical Examiner	İ	1141	^{ch line.} Hypertensive Athe	rosclerotic				ardiac or re	spiratory arres	st, snock, or	пеап	Approximate Interval Between Onset and Death
tecuted and	I Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence	ence of p								
760, icate be exe physician a the burial -	Medical	IF FEMALE:	AMENDED #4a, p		925,	3/16/20	12,WS			23d. Date	of delivery	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time 9 Unknown	e of death 5		al death 3 er (Specify)	Ectopic	pregnancy		Month	n D	ay Year
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Tn the Hospit within 24 hour Tn the Funer completely fill	edical	one) 2 Medical Examiner	an: To the best of my kn On the basis of examina and manner stated.			on, in my opinio	n, death occ		e time, date a	nd place, an	d due to the	e cause(s)
		29b. Signature and title of certifier	111	A	7	29c. Licen:	M.E.			March 1		ith, Day, Year)
4			tant Medical Exan	niner 90	0 W. B	altimore Stre	eet, Baltir	more, Mi	21223			
St Regist		31. Date filed (Month, Day, Year) NAR 1 6 2012	32. Registrar's S	Signature Sarks	1						<u>.</u>	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

**Funeral** Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director		1. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ሺ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces?  1 X Yes 2 N If Yes, Give Year or Dates:		5. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【XNo	ispanic Origin? (Spe in, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Af	
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O	2	29a. Certifier 1 Certifying	building, etc g Physician: To the best of Examiner: On the basis of	f my knov	wledge, dea				e(s) and manner	
Medical	2	29b. Signature and title of certifier	and manner sta		and/of I	29c. Licens		29d.	Date signed (Mon	nth, Day, Year)
	3	30. Name and address of person			n 23a) (Type	e, Print)				ore, MD, 21
State strar	3	31. Date filed (Month, Day, Year) NAR 1 6 2	012 Les Registra	s Signa	ture La	New .				

DHMH 17 Rev 1/2001

12-02053 Ríchard B. Barton

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To June 1 list only one cause on each line.    Sequentially list conditions cause (First disease)   Sequentially list conditions condition resulting in death)   Sequentially list conditions (asset)   Sequentially	E E B B	i		Sounds	Mousil, D	2VIV.	-					Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part of the Part o
Withing Blunt Force Injuries    Due to (or as a consequence of):			23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the death. Do	not enter the	e mode of dying, s	uch as cardiad	or respiratory a	rrest, shock, or h	eart	Between Onset and
Due to (or as a consequence of):    The condition of setting in death)   Due to (or as a consequence of):			Immediate Cause (Final disease	_{a.} Multiple B		es						Death
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UNPENDED   AMENDED   AME		튑									1-17	
220. Was decedent pregnant in the past 12 months?    Type    ted Insit	Ä	events resulting in death) Last	•	a consequence or).								
220. Was decedent pregnant in the past 12 months?    Type    execu an and al - tra	<u>s</u>	UNPENDED	¬	)								
29b. Signature and title of certifier  29c. License number O.C.M.E.  March 12, 2012  30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, Day, Year)	60, ate be hysici	3	IF FEMALE:	23c. If yes	s, outcome of pregnan					23d. Date	of delivery	
29b. Signature and title of certifier  29c. License number O.C.M.E.  March 12, 2012  30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, Day, Year)	387 rtifica ling p			I I LIVE			aldeath 3	Ectopic preg	nancy	Month	D	ay Year
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29b. Signature and title of certifier  29c. License number O.C.M.E.  March 12, 2012  30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, Day, Year)	Iled in in	팋	dete		Major Road /	Highway			Outer inters	(State) tate 695 near h	wy 702,	Baltimore , MD
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29b. Signature and title of certifier  O.C.M.E.  March 12, 2012  30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, Day, Year)	o the o the smplet	ğ	one) 2 Medical Exa	and manner		or investigati			d at the time, dat			
30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	H \$ H S	Ž	29b. Signature and title of certifi	ier						200		nth, Day,Year)
Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			Mr		M	1	O.C.N	1.E.		March 12	, 2012	
State 31. Date filed (Month, Day Year) 32. Registrar's Signature	0 1-1		,				A/ Dalkiman /	Stroot Dell	timoro MD 3	1223		
State 31. Date filed (Month, play year).	MIN						v. paitimore :	oneer, Ban	uniore, NID 2	. 1223		
			MAR 1 6 201	2 Beneur	Cyloral Solyllatur	enter			. 00%	ec.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Lowell J. Bishop 14/PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Lak the Hospice at Sa comic 8. Date of Birth 9. Birthplace (State or Foreign Country) thio If Under 7. Age (In yrs. last birthday) **Funeral** X 1 M 2 D F Hours (MO47:133/1949 290-48-4052 62 Director 28a-f show 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified Yes 2 No MD Wicomico Salisbury 10e. Street and Number ö 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 731 Camden Avenue 21801 **USA** death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 0 W € 11 010 1215-0036 Itimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: "natural", Specify Completed 3 Divorced 4 Divorced White the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) Professor Education 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ൧ Page 1 and 2 should be Edward Bishop Elizabeth Large 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is:
any injury or other traun 731 Camden Avenue, Salisbury, MD 21801 Daniel Domer / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 🛛 Cremation 3 🗌 Removal from State 3/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall ( Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ MALIGNANT RECTOS/GMOIL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law has perform this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 Tyes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: Natural 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 No Accident Investigation Funeral Director; Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Opertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an and addless of person who completed cause of death (Item 23a) (Type, Print) 733 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene & U For State Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Month 1 Physician/ Year 5:50 AM BENDIT ALIG L 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3395 Silver Spring Montgomery S. Leisure World Blvd. If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours 217-34-1278 Director 1 X M 2 □ F Yrs August 24, 1935 76 New Jersey show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 3395 S. Leisure World Blvd. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? 1 Yes 2 No 1955-Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 1959 White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Electronics Elementary/Secondary (0-12) College (1-4 or 5+) Distribution Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Salig L. Bendit, Sr. Elsie Itro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3395 S. Leisure World Blvd., Silver Spring, MD 20906 Glenna B. Bendit /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of March 13, 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 Burial 2 K Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. nterval Retween Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last this certificate has been signed by the attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Manner of D ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Director; After 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 16810 Name and address of po son who completed cause of death (Item 23a) (Type, Print) Prince Philip State 6 201 Registrar MAR 1

12-02104 Dion Brandon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certific	cate of Death		Reg	g. No.	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	andon			March 7, 20	Dey Year	3. Time of Death 1600 hrs
	4a. Facility Name (if not institution, give Good Samaritan Hospital	street and number)	4b. City, Town, 6 Baltimore	or Location of Dea	th	4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 217-98-2885	7. Age (In yrs. last bi	**	ear If Under 24H ays Hours Mi	n.	1,1981 Co.	
d how any Ze.	Usual Residence of Decedent  10a. State  10b. County  MD	10c. City, Town	n or Location				10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show tified at once.	10e. Street and Number 4202 Stanwood A		10f. Zip Code 212	06	10	g. Citizen of What Cour	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  Yes, Give Year  Or Dates:	13. Was Decedent of H If Yes, specify Cub  1 Yes 2 X N	an, Mexican, Puer		14. Race - Americ White, etc. Specify: B1	can Indian, Black,
5-0036 ed within 72 hours; yegiene. other matturi the Medical Exami	15. Decedent's Education (Specify onli Elementary/Secondary (0-12)	/ highest grade completed) 16a College (1-4 or 5+)	Decedent's Usual Occup during most of working li unemploye	fe. DO NOT use re		16b. Kind of Business/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/liness/l	ndustry
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica To Be Comple	10th 17. Father's Name (First, Middle, Last) Donald Brandor		<del>_</del>	18.Mother's Nan Pegg	ne (First, Middle, M y Chamb	ers	
MD 21 12 should th and Mer 17 is man To	19a. Informant's Name/Relationship (Ty Peggy Chambers	(mother)	9b. Mailing Address (Str 1202 Stanw	ood Ave	. Balto	,Md. 2120	16
Baltimore, cemit. Pages I and Department of Heal Important: If iten injury or other tra	20a. Method of Disposition  1 X Burial 2 Cremation 3   4 Donation 5 Other Specify:	Removal from State crema	of Disposition (Name of datory or other place)  Lawn Cem.		Date r.16,20	20c. Location - City or 12 Balto	
Balti permit. Departu Importi injury o	21. Signature of Funeral So. Licens		1412 E.	Preston	St. Ba		21213
Physician /Medical Examiner	_	h line. C <b>omplications of</b>				st, shock, or heart	Approximate Interval Between Onset and Death
	Sequentially list conditions, b	ue to (or as a consequence of):  ue to (or as a consequence of):					
ted 1 Insit Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence of):					
an and all - tra	d.  X UNPENDED	AMENDED 23a, 27, 28a	-f,per me,g	26 4-4-1	2 sm		
iox 68760, eath certificate be attending physici for use as the burins recipion of sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1 Live birth  4 Pregnant at time of death  9 Unknown	y 2 Fetal death 3 5 Other (Specify)	B Ectopic preg	nancy	23d. Date of delivery Month D	eay Year
cords, P.O. Bc (aw requires that the det has been signed by the a 2 should be detached for upleted by Phys	Part II. Other significant conditions		ng in the underlying cause	e given in Part I.		pacco use contribute to	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as edical Certification: To Be Completed by Physician					24a. Was a autops perforr	y prior to c ned? death?	topsy findings available ompletion of cause of
of Vital Recoing Physician: The law After this certificate has bineral director, page 2 son: To Be Comp	25. Was case referred to medical examiner?	ospital: 1 ✓ Inpatient 2 ☐ ER/0	26.Pla	ce of Death (Chec	k only one)	Residence 6 Other	
ing Physi ding Physi After this funeral dir	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 28b (Month, Day,Year)	. Time of Injury 28c, Ir	njury at Work?  Yes 2 X No	28d. Describe h	ow injury occurred was shot	
Division of Vital Rec patal or Attending Physician: The I nours after death. neral Director: After this certificate b filled in by the funeral director, page Certification: To Be Com	2 Accident Investigatio 3 Suicide 6 Could not b	28e. Place of Injury - At home,	farm, street, factory, office		28f. Location (Stor Town, Stor	treet and Number or Ru ate) 900 Belgi	ral Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier (Check only one) 2 Medical Examiner:	n: To the best of my knowledge, d On the basis of examination and/or	in vehicle eath occurred at the time, investigation, in my opini	date and place, as on, death occurred	Baltimo  Indidue to the cause If at the time, date a	e(s) and manner as state	ed. e cause(s)
To with To con	29b. Signature and title of certifier	and manner stated.	29c, Lice	nse number		29d. Date signed (Mor March 14, 2012	
3)	30. Name and address of person who co Pamela E. Southall, MD	ompleted cause of death (Item 23a Assistant Medical Examin		ore Street, Ba	timore, MD 21	223	
State Registrar	31. Date filed (Month, Day, Year)	62. Registrar's Signature	barles				

				tems 23a pe	r dr.,	g <b>923', (</b> Cer	tificate of l	<b>2dhb</b> Death	- I	Reg. No.	J 1 4	0013
Physician			1. Decedent's Name (First, Middle, Last)  Alice Victoria				Pownott		2. Date of De Month Marcl		Year	3. Time of Death 9:20 A M
W. M.	Medic		4a. Facility Name (if not institution	· · · · · · · · · · · · · · · · · · ·	<u>Victoria</u>		Barrett  4b. City, Town, or Location of Death				13, 2012 9:20	
	Examir	ier	13616 Alliston Drive				Baldwin			Baltimore		<b>-</b> 0
	Funeral		5. Social Security Number		Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hr		th	9. Birthp	lace (State or Foreign
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		011-09-1187 Usual Residence of Decedent	1 □ M 2 💢 F	93	Yrs.	Months Days	Hours Min		1,1918	Mass	achusetts
		Funeral Director	10a. State 10b. County		10c. City,	Town or Loc	cation				10	0d. Inside City Limits
			Maryland Balt:	imore	Baldwi					10g. Citizen of What C		1 ☐ Yes 2 🕅 No
			13616 Alliston	Duite	***		10f. Zip Code 2101.3			II.S.A		try?
			11. Marital Status	12. Was Deceden	t Ever in U.S.	13. V	Was Decedent of Hispanic Origin? (Split Yes, specify Cuban, Mexican, Puert		Specify Yes or No-	14. Rad	14. Race - American Indian,	
036		þ	1 ☐ Never Married 2 ☐ Ma 3 🕅 Widowed 4 ☐ Divorce	, If Yes, Give	1 ☐ Yes 2 🔼 No		1 ☐ Yes 2 X No Specify:			Black, White, etc.  Specify: White		
215-0036		Completed	15. Decedent's Education (Specify only highest grade completed,		(Give		dent's Usual Occupation kind of work done during most of working		orkina	16b. Kind of E	of Business/Industry	
2121		Com	Elementary/Secondary (0-12)	College (1-4 o	College (1-4 or 5+)		DO NOT use retired) Derator			Telephone Company		
שנ		Be	17. Father's Name (First, Middle,	Last)		ΔĮ	ELALUI	18. Mother's Na	ame (First, Middle,	_		опрану
Maryland		2	Mi	chael J		lughes			Beatrice	е А.		Loftus
2			19a. Informant's Name/Relations				g Address (Street			-		
5			Barbara Barre 20a. Method of Disposition		20b. Pla	ce of Dispos	Allisto sition (Name of		Baldwir Date	20c. Location		21013 wn, State
2			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	Specify)	te Mass		gery <del>t</del> rether place L'Cemeter	, i J I	6-2012	Bourne		4
baltimore,			21. Signatur Weurood Selvice	Licensee		22	Name and Addre	ss of Facility Ri Road	uck Tows Towson,	on Fune: Marylar	al Ho	ome, Inc. 1204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
	Ph _{sician} Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. DEMEN			rovascula	ar Accid	ent		_	Onset and Death
	Examiner	L	Due to (or as a consequence of):  Vascular Dementia  Sequentially list conditions,									
	sit sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or a	Due to (nr as a consequence of):							
	certificate be executed nding physician and use as the burial-transit		that initiated events resulting in death) Last	c. Due to (or a	c. Due to (or as a consequence of):							
00/0		Medical		d								
200		Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						23d. Da	ite of delive	erv
	death he atter		in the past 12 months? 1 ☐ Yes 2 🗶 No 9 ☐ Unknown	4 Pregnant	1			ncy			Month Day Year	
	cian: The law requires tha ertificate has been signed ector, page 2 should be d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to								ribute to the	e cause of death?
'n		ed by	1   Yes 2   No 3   P							3 🗌 Prob	ably 4 Unknown	
חברטום		Completed							24a. Was	psy	prior to con	sy findings available npletion of cause of
											death? 1 🗌 Yes :	2 🗆 No
		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:			Oth	ace of Death (Cheer:			* -	
DIVISION OF VITAR	y Phys er this eral di	e: To	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at						Home 5 Resident	dence 6 🗌 Oth		
:	Attending ar death. ector: After by the fune	ficat	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be				M 1 🗆	<br Yes 2 □ No				
	or Atter de Directo	Certificate:	4 ☐ Homicide 6 ☐ Could 4 ☐ Homicide determ	jury - At home, farm, street, factory, office ic. (Specify)				28f. Location (Street and Number or Rural Route Number City or Town, State)			Route Number,	
1	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									ed.
			001 0: 1 1:11 1 1:15						the cause(s) and r	e cause(s) and manner as stated. 9d. Date signed (Month, Day, Year)		
			> Muser DNO NO				R130272			3/13/2012		
)			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
'			TRACIE L. MOR	GAN, CRNP	2300 D	ULANE	Y VALLEY	RD. TI	MONIUM,	MD 21093	3	
	Stat Registra		31. Date filed (Month, Day, Year) <b>MAR 1 6 20</b>	12 32. Regis	trar's Signatur	bar	4					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMELIA BARBARA CARTER 2012 MARCH 14 12:05AM Medical own, or Location of Death **CLINTON** a. Facility Name (if not institution, give street and number) SOUTHERN MARYLAND HOSPITAL 4c. County of Death
PRINCE GEORGES 4b. City, Town Examiner Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours 214-22-7600 Director 85 Yrs. 1 M 2 X F 8-23-1926 MARYLAND 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State Director or 28a-f sh notified a MD ANNE ARUNDEI LOTHIAN 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n pe Funeral ms 23a must be 181 MAIN STREET 20711 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iter Black, White, etc. by Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. anter if item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Examin. 1 Never Married 2 Married 1 Yes If Yes, Give 21215-0036 1 Yes 2 No Specify: WHITE Specify: Completed 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ 12 CIRCUIT STATE OF MARYLAND COURT Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **GEORGE** COLLINS HADDIE DeGELE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PARKVILLE, MD 21234 MEAGAN GERLACH/GRANDDAUGHTER 2818 ASPHENHILL ROAD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I Important: If its any injury or of once, 1 X Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 3-17-2012 PARKVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME Signature of Funeral Service 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Ca Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 or Attending Physician: The law requires that the death certificate as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown phone 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performed death? 1 ☐ Yes 2 ☐ No Yes 2 **Division of Vital** Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at s after death. I Director; After t Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined ouilding, etc. (Specify) City or Town, State) Hospital 24 hours Medical 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the vithin 2 To the comple 29b. Signature and title of certifi 29d. Date signed (Month. Dav. Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cole 125-PM ren Medical 4c. County of Death . Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 483 Director 1 XM 2 🗆 F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 Yes 2 ☐ No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ō ms 23a or must be n Funeral 21202 items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican. etc. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 X No Specify Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life, DO NOT use retired) condary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or com-19a. Informant's Name/Relationship (Type, Print) or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number 3729 Drive Balto. 21207 ones unnie MD Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of OwingsHills 12012 1101 E. North Ave. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March FIH-East 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Di to (or as a consequence of): **Examiner** Sequentially list conditions, it any cause. Enter Underlying Due to or as a consequence of Examir use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: es, outcome of pregnancy

Live Birth 2 
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or Attending Physician: The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 🗌 Yes 12 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: Natural 28d. Describe how injury occurred injury 5 Pending 2 🗌 No Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 E only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 'LX dress of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month M James Larkin Casterline, March 2012 1535 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Director 248-52-4782 1 🔀 M 2 🗆 F 80 Dec 25, 1931 South Carolina or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Silver Spring 1 ☐ Yes 2X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be an "natural", or items 23a Medical Examiner must b Funeral 3148 Gracefield Rd. #402 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Completed by 1 Never Married 2X Married 72 hours after 1 Yes 2 No Specify: If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. narked other than "r natic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Biochemist Federal Government is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Larkin Casterline, Sr. Hattie Steppe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy C. Casterline/wife 3148 Gracefield Rd. #402 Silver Spring, MD 20904 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 03/16/12 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility
Going Home Cremation Service 21. Signature of Funeral Service Licensee P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ a Respiratory Failure disease or condition Medical resulting in death) **Examiner** Pulmonary Interstitial Fibrosis vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of The law requires that the death certificate be executed Exam burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 🔀 No မှ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending work?
1 Yes 2 No s after death. 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number filled in by determined To the Hospital within 24 hours a To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10 V

21215-0036

Maryland

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

State Registrar

only one 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugeno Machado, M.D. 3110 Gracefield Rd.

DHMH 17 Rev 06-201

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Silver Spring, MD 20904

D24035

29d. Date signed (Month, Day, Year)

March 14, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Roger Evan Carr March 2012 9:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3000 Crest Ave. Cheverly Prince George's Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min Days Hours **Director** 1 🔀 M 2 🗆 F 447-44-5739 66 Aug. 12,1945 Oklahoma Usual Residence of Decede show notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 28a-f 1 🗌 Yes 2 🔀 No MD Prince George's Cheverly 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 20785 USA 3000 Crest Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. Armed Forces?

1 🔀 Yes 2 🗌 No
If Yes, Give
Year or Dates:1964-74 ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Government Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Daisy Lehman Gordon Harlan Edison Carr other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a Lin Bessett / Friend 3000 Crest Ave. Cheverly MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State injury or Department Important: If any injury or Final Journey Crematory 3/16/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of uneral Service 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. heckrotte, P.A. Clarksville, M el M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 6 months Metastatic Malignant Melanoma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2x No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform page certificate 2 X No 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **X** No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No 1 X Natural 5 Pending injury after death I Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined filled in City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Suite 107 College Park, MD 20740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7305 Baltimore Blvd.

Date filed (Month, Day Year MAR 1 6 2012

D26287

March 14,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 400 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 500 4 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death RIVERVIEW NURSING CENTER BALTO. **ESSEX** Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) Months 218-05-0879 93 Director 1 🗆 M 2 🗶 F 8-18-1918 MARYLAND Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified COLUMBIA 1 Yes 2 X No PA. BLOOMSBURG 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 839 SCOTCH VALLEY DRIVE 17815 USA permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items, any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedon Armed Forces?

1 ☐ Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
4TH College (1-4 or 5+ ASSEMBLER UMBRELLA COMPANY Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DANIEL BECCHIONI CARMELA LAZZARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANGELINA LAPCHAK DTR. 839 SCOTCH VALLEY DRIVE BLOOMSBURG, PA. 17815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 3-17-2012 | BALTO. MD 21. Sign Jare of Funeral Service Lice 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. BALTO.MD. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between n nd Death Immediate Cause (Final Ph, sician/ nevo disease or condition Medical resulting in death) Examiner Sequentiary fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death detached g Unknown P.O. signed by detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, is certificate has been significate, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate Yes 2 2 No 2No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 8c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural (Month, Day, Year) 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completely filled Medical 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Catherine Elizabeth Campbell 2:45 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Glen Burnie Baltimore Washington Medical Center Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213 78 4561 **Director** 1 □ M 2 🕱 F 70 08/21/1941 Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location notified at 10a. State Director 1 Yes 2 X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be to 21233 9055 Meadow Heights Road U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc ģ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 xNo Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 lith and Mental Hygiene. 27 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) None N/A 5th Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Catherine Quasky Charles Campbell Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 First Avenue Baltimore, Maryland 21225 e 1 and 2 s of Health Mildred Mewshaw / sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 03/20/2012 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Signature of Funeral Service License cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Part 1. Enter the disease, shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final - ºh .sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami and the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural Accident (Month, Day, Year) 5 Pending work?
1 Yes 2 No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number erson who completed cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1 4 Physician/ EDWARD CIERNIAK 1146 PM MARCH Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE N/A CIT HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 218 05 7396 **Director** 1 🛛 M 2 🗆 F 94 12/26/1917 Maryland Usual Residence of Decedent or 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 106 - 8th Avenue 21225 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black White etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates, WW II 1 Yes 2 No Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Electric Company the 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Andrew (Henry) Cierniak Antonina (Tina) Grabowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lottie Cierniak / Wife 106 - 8th Avenue Baltimore, Maryland 21225 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State MD State Veteran Cem: 03/19/2012 Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure (Daylonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ATHEROSCLEROTIC CARDINYASCULAR Medical Due to (or as a consequence of) Examiner HYPERTENSION 40 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director: After tl Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D70358 2012 MEDICAL DOCTOR MARCH 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANDVER STREET BALTIMORE MARYLAND 21225 KENNETH MWATHA 31. Date filed (Month, Der Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March ^{Year} 2012 Delores Lorretta Combs 6:38  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 870 Planters Wharf Road 9. Birthplace (State or Foreign Country) Virgina Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth **Funeral** Months Hours Month, Day, Year, 04/01/1924 1 M 2 XF Director 87 578-22-8183 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Calvert Lusby 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9 "natural", or items 23a o Funeral 20657 870 Planters Wharf Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black. White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Il Hygiene. Bindry Worker Print 5 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o . c, Mary.
. c, mit. Page 1 and 2 should be 1, Department of Health and Merlimportant: If item 27 in any injury or other once. ည Unkn. Unkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Norman Combs / Son 870 Planters Wharf Road, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 3/16/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deal Immediate Cause (Final Physician/ arci disease or condition resulting in death) ml Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a Yes Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 100 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined To the Hospital o within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 41680 luiss Bessie Dr.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed Month, Day, Year)

6 2012

DHMH 17 Rev 7/2009

Baltimore, Maryland 2121

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vasso Christiansen Η. MARCH 08:15 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL RALTIMORE n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Dec 26, 1 9. Birthplace (State or Foreign 1 🗆 M 2 🖵 F Days Director 212-32-7871 Country Greece Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Catonsville 1 Yes 2 No 5 10e. Street and Number , or items 23a or aminer must be r 10g. Citizen of What Country? by Funeral 707 Maiden Choice La., Apt. 9113 21228 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) of Health and Mental Hygiene. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental i Important: If item 27 is marked cary injury or other traumatic events. ပ <u>Panagiotis</u> Hondrous Popi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Catonsville, 19a. Informant's Name/Relationship (Type, Print) Ross Christiansen-husband 707 Maiden Choice La., Apt 9113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XXurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greek Orthodox 3/17/12 Woodlawn, MD Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death URINARY TRACT INFECTION disease or condition resulting in death) 1 Day Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions Examine Due to (or as a consequence on) cause. Enter Underlying Cause (Disease or iinjury UNIG CANCER that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Fibaillation, TIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Yes 1 MInpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) No And Some P25499 03/13/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anil Nadipelli 900 S. caton Avenue Baltimore 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marie Hannah Day March 2012 11:15P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Apt 2B 3381 S. Leisure World Blvd Bldg 93 Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours **Director** 91 167-16-3267 1 M 2 X F Nov. 23, 1920 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 X No ö 10e. Street and Numbe items 23a or ner must be r 10g. Citizen of What Country? Apt 2B Funeral 3381 S. Leisure World Blvd. Bldg. 93 20906 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? ö by 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 104 Baltimore, Maryland 21215-0036 "natural", dical Exar 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 1943-46 edical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) er than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker event, th Own Home Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ျ Daniel Francis Casey Hannah May Waples 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Campbell / daughter 502 Auckland Way Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 3/17/12 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory Woodbine, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, M M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ Sovere disease or condition resulting in death) wank nears Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or) burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year the a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perforn 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending death. Accident
Suicide 1 🗌 Yes Investigation pletely filled in by the 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

29a. Certifier

(Check

only one)

hartene 31. Date filed (Month, Day,

MAR 1 6 2012

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ozanne

Blankfard mc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

043207 3305 North 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OVOTTO 201 4:15 AM DaN MarcH Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death KINGS Meade Way olumbia HOWORD If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 242-50-5429 1 M 2 F n Pay, North Carolina 6 **Director** or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director HOWARD MD Columbia 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral IN95 Meade Way 21046 11.5.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 ☑ Widowed 4 ☐ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ousewit DOMESTI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5003 · Battimore, MD daughter permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 3-19-2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License FUN. eral Home Howell 22. Name and Address of Facility 10220 Guiltord Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARDIONYOPATHY Physician/ disease or condition resulting in death) nonth Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 🗌 No a | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONHRY ARTERY DISEME 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Tes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending Pawithin 24 hours after death.
To the Funeral Director: After Natural 5 Pending n 24 hours after death.

In Funeral Director: A:
pleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MARCH 17 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) frep Le Shakunmale Sanhapord 9650 21045 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

68760

Box (

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2012 Year 3:40 AMPhysician/ March Marjorie Ε. Dawson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Collingswood Nursing Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours 578-07-8359 July 12, 1915 Washington, D.C. 1 M 2 X F **Director** 96 Usual Residence of Decedent 10d Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State items 23a or 28a-f sho her must be notified at Director 1 Yes 2 X No Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 20850 11 Great Pines Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 27 is marked other than "natural", or ite traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 iment of Health and Mental Hygiene. tant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) Railroad Association Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillie Hielman 2 Roland Murtha Brennan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 Great Pines Court, Rockville, Maryland 20850 Mary E. Rozansky / Daughter other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State permit. Page 1 a
Department of h
Important: If ite
any injury or ot Silver Spring, Maryland Gate of Heaven Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home, Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 21. Signature of Fundal Service Lice M01305 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Se quentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-transit that the death certificate be executed and that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 3 Ectopic pregnancy 23d Date of delivery 23b. Was decedent pregnant Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Tes 2 No 3 Probably 4 Unknown Records, the Hospital or Attending Physician; The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Jas performed? Yes 2 No 2 🔲 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 28b. Time of Certificate: 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 [] Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Genifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and tele 700252240 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blvd., Suite 330, Rockville, Maryland 20850 Heshmat, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ 5:20 PM Joan Tharp Daniels Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Medstar Montgomery Medical Center</u> 01ney Montgomery If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) Hours Country) Director 1 □ M 2 🏋 F 578-40-4620 Usual Residence of Decedent 81 July 22, 1930 Washington,D.C Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Florída Charlotte Charlotte Port Charlotte 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3303 Brooklyn Avenue United States Was Deceue. Armed Forces? ☐ Ves 2 🔀 No 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates 3 - Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with th and Mental Hygien 7 is marked other ti Head Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည traumatic George Reginald Bodmer Helen Roberta Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau Tall Cedar Court, Germantown, Maryland 20876 <u>Kenneth Lee Tharp/ Son</u> altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Darnestown Presbyterian
Church Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State March 15, 2012 4 ☐ Donation 5 ☐ Other (Specify) Darnestown, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Fund al Service Licensee M00335 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial physician s the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death g Unknown Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe certificate has page 1 Yes 2 No Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes မ 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending neral Director: A y filled in by the f M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00071214 avanus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive, Olney, Maryland 20832 Manju Mavanue, M.D. 31. Date filed (Month, Day, Year) MAR 1 6 2012 State Registrar

DHMH 17 Rev 06-2011

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AMEND TTEM#20b.c. perFH. G925, 3/16/2012, WS
State of Maryland / Department of Health and Mental Hygiene 2 | | | / | 1 - State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Evans 1750 2012 М (200mg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Season's Hospice Randallstown If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 217-52-7493 Director 1X M 2 □ F 07 31 49 MD 62 Usual Residence of Decedent show 10b. County with the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Baltimore NA MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 22 North Kosseth Street items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 

XYes 2 □ No
If Yes, Give Black, White, etc. ō 1 Never Married 2 Married by within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Housing City of than Dept should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Baltimore 12th Grade Office Assistant na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarice CoX t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or George W. Evans other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21229 22 North Kosseth Street, Sarah Evans-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other state) Owings Mills
Baltimore, Md Date Ukn 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 3/20/12 Carrison Forest 21. Signature of Funeral Service 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 a Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final Ph sician/ 1849 Cance Jatic Cavs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year the a s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ★ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an sate has l autopsy performe certificate 2 No 1 Yes 25. Was case referred to medica inpatient Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{6} \) Other (Specify) ္ဝ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA hospice this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu Accident Investigation M 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 37573 March 11, 2012 By 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Baltune MD SISO 2835 5, MAR 1 6 20 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month POS XIME 2/2012 Medical Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medica Burnie Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 578-62-133 Country) **Director** 1 M 2 W 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified AA 28a-f MD evern 1 Nes 2 No 10e. Street and Number ò 10g. Citizen of What Country? be r items 23a o Funeral LLSA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. event, the Medical Examiner Black, White, etc. or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NPT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NUISE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catie injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State Department or Important: If any injury or once. 4 Donation 5 Other (Specify) Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Uterine Onset and Death Ph sician/ 5 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Securitally list or ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examir and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 1 Yes 2 9 Unknown Pregnant at time of death Day Year the Unknown P.O. | signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Yes 2 certificate 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 1 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident Investigation Could not be 1 Yes 2 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier icense number 29d. Date signed (Month, Day, Year) 2012 avch 13, 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Ve 12/25 UVMIR

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

6 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh 9925 3-16-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death andglistow 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Unde 7. Age (In yrs. last birthday) Funeral 1 D M 2 Months Min. 602 Yrs. Director 28a-f show 10b. County e filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No imore ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3401 21207 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. is marked other than "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ■ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. orKer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Willie J. Harris Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a In portant: If item 27 is a y injury or other tran MI) 21207 timore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) p-rmit. 21. Signature of Funeral Service Licenses Greene Funeral services 21133 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed the burial-transit Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes No Month Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? certificate 2 No Yes Yes To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Division of Vital Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 00626 March 2012 address of person who completed cause of death (Item 23a) (Type, Print) MD 401 1 and allstown anyer 01 1000 31. Date filed (A State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1719 Mary Maria Elizabeth Fitzhugh 2012 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 XM 2 □ F Months Days Hours 03-08-1929 Director 214-26-8187 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Maryland 1 Yes 2 No Owings Mills, Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 5 Chins Court 21117 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö 1 Never Married 2 Married þ Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black "natural" 3 XWidowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home the Homemaker <u>12th Grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Charles Jones Madeline Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Angelina E.Fitzhugh/Daughter 2055Corbett Rd. Monkton, Maryland 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State nent of Important: If in any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Garrison Forest Cem.3-19-12 Owings MillsMD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Balto. MD.21215 eri 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each if e Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a conse dence of): **Examiner** year Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): as the burialattending physiciar Physician/Medical IF FEMALE: nse Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Day Pregnant at time of death Month Year detached á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 🔄 No Yes 2 No Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 은 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after death. Natural 5 Pending 1 Yes 2 No 2 Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

of Vital Hospital or Attending Division 24 hours To the I-within 2. To the I-

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

DHMH 17 Rev 7/2009

State Registrar 29b. Signatur

Evin

31. Date filed (Month, Day, Year)

5201 Lock Raver Block

pleted cause of death (Item 23a) (Type, Print)

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**ORIGINAL** 

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and	be filed ental H ked ot c ever	To B	17. Father's Name (First, Middle, Las  JOSEPH FERRARI								(First, Middle,	Maiden	Surname)					
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Baltimore,	0 1		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ite C	Place of Dispo emetery, cren ANTIC (	natory or o	ther place	· .		ate		ocation - City					
altii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice		KILE				s of Facility	-15- SC	ZOTZ J HIMUNET		N BURN NERALHO					
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Box	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medica	PEWALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown	23c. If yes, outcom  1  Live Birtl  4  Pregnan  9  Unknow	h 2 ☐ Feta t at time of d	l death 3 🗆	Ectopic p Other <i>(sp</i>		/				23d. Date of Month	delivery Da	y Year			
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Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Il Certificate:	3 Suicide 6 Could no 4 Homicide determine	be 28e. Place of I	njury - At ho etc. <i>(Specify)</i>		et, factory	, office		2	8f. Location (S City or Tow			Rural Ro	ute Number,			
	the Hospit nin 24 hour the Funera npletely fill	Medical	(Check 2 Medical Exa only one) 3 Certifying No	nysician: To the best miner: On the basis o urse Practitioner: To	f examination	and/or invest	igation, in r	my opinior	n, death occ	curred at t	he time, date a	nd place	, and due to th	ne cause(	s) and manner stated			
	Norith		29b. Signature and litle of certifier	ICAMP			290	214	number 979	12		29d. Da	te signed (Mo	nth, Day,	Year)			
_	21		30. Name and add ess of person who	completed cause of		23a) (Type, P <b>VEY VAI</b>	•	RD	ттмог	итим	, MD 21	UOS						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 13, 2012 Physician/ Ruth Edna Fargo 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Bel Air Lorien Bel Air If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Hours 213-20-9218 Director 1 🗆 M 2 🖳 F 96 April 15, 1915 Pennsylvania Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗆 No Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? ō ms 23a or must be r Funeral 1909 Emmorton Road, 21015 U.S.A tal Hygiene.

A other than "natural", or items
event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 11.5 Sales Department Store Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Scott W. Carr Marv Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas L. Fargo-son 1504 Balmoral Dr., Bel Air, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Gardens of Faith 1 XBurial 2 Cremation 3 Removal from State 3/19/12 Overlea, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ DEMENTIA disease or condition resulting in death) ENDSTAGE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Year þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HTN, HYPOTHYROIDISM, ANEMIA 1 ☐ Yes 2 💯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? THROMBOCYTOPENIA, GERD OSTEDARTHRITIS 24a. Was an performe 1 ☐ Yes 2 🗷 No certificate 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 4 - Nursing Home 5 - Residence 6 X Other (Specify) ASSISTED 은 1 Inpatient 2 ER/Outpatient 3 DOA ours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Funeral L Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 622 S. UNION AVE, HAVRE DE GRACE, MD 21078 SURESH DHANJANI

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 11^{Day} 2012 10:42 A M Rose Fewster Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Min **Director** 219-12-9366 87 1 □ M 2 🗶 F June 3, 1924 Maryland or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 No Freeland 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a o Funeral 21502 Kenney Mill Road 21053 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent 2.2. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 9 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Glock Frank Michaels Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Leonard J. Fewster-husband 21502 Kenney Mill Rd., Freeland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/16/12 Owings Mills, MD Garrison Forest Vet Cemet: 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William G. Dau Ruck Towson Funeral Home, Inc. 1050 York Rd Towson. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ evebra ascular day disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. 57,550 Balding MD21204 6535 N - Charles Bohn 31. Date filed (Month, Day, Registrar's Signature State MAR 1 6 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Fulca Month Margaret Helen 12:48 p^M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Months (Month, Day, Year) **Director** 89 216-16-1260 1 M 2X F April 16, 1922 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location Director MD Baltimore 1 Yes 2 No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 2525 Pot Spring Rd., S-303 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ian "natural", or iter Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🐒 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Secretary and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Philbin Marguerite William Busick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Joseph L. Fulca-husband 2525 Pot Spring Rd., S-303, Timonium, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 3/16/12 Parkville, MD 4 Donation 5 Other (Specify) 21. Signature of Edneral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) RENAL DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or mjury that initiated events burial-trar resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Left death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform death? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and time 29d. Date signed (Month, Day, Year, 2012 of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

Registrar

State

MAR 1 6 2012

FULCA

MARGARET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nend #10e &f Per FH G925 3/16/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ Jackie Virginia Graves 2012 March 1500 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2226 Maryland Avenue Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 212-80-0742 Director 53 1 □ M 2X F Jan. 19,1959 Maryland Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Marylanþ Baltimore Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 21230 2226 Maryland Ave. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 XNever Married 2 Married Yes 2 😾 No Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Home Healthcare Elementary/Secondary (0-12) College (1-4 or 5+) Nurse<u>'s Aide</u> 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be. Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewo မ George Graves Audrey I. Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Archie Graves/Brother 1020 N. Broadway St. Baltimore, MD 21205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State -13 - 1203 Carmel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 21. Signat of Funeral Service Licenses 22. Name and Address of FaciliChatman-Harris Funeral Home 240 Reisterstown Rd Baltimore, Maryland ac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death near + Immediate Cause (Final evotic Physician/ thero disease or condition Medical resulting in death) Examiner ension equal tielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 the attending phoched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗶 No detached 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò intection Records, 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown Be Completed peen . Were autopsy findings available prior to completion of cause of tection 24a. Was an has page 2 autopsy insulticiency perform death? 1 Yes 2 X No 1 ☐ Yes 2 🛣 No Division of Vital or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? 1 

✓ Yes 2 

No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it iniury 1 X Natural 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completely filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) WLONBARD STR, BALTIMORE AD 21701 UCHWA L ULRIK 31. Date filed (Month, Day, Year) State Registrar

-	E
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed

			Please Type Amend # 5 ar	or Print in 1	3lack lr	ndelible Inl	k. Ensure	All Copie	s Are Leg	ible.		
			1 - State Registrar			tificate of E		- Wichtai Hy	Reg. No. 20	12	08167	
	Physicia		1. Decedent's Name (First, Middle, Last) Kenneth Lee Green					2. Date of De Month	Day	Year	3. Time of Death	
18 C 18 Jan	Medic Examin		4a. Facility Name (if not institution, give street and	number)		4b. City, Town, or	Location of Dea	MARCH eath	4c. County	of Death	0859 AM	
أمريت	Eupoval		SINAI HOSPITAL OF B 5. Social Security Number 6. Sex	ALTIMORE  7. Age (In yrs. Ia	est hirthday)	BALTIM If Under 1 Year	ORE If Under 24 H	rs. 8. Date of Bir	th	9 Rinthal	ace (State or Foreign	
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0036	urs afte tural", al Exan	ted b	3 Widowed 4 Divorced If Yes	, Give or Dates.		Yes 2 🗓 No	Specify:		Specify:	Blac	k	
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lanc	be file fental h rked o tic ever	To E	17. Father's Name (First, Middle, Last)  Isaac Green					ame <i>(First, Middl</i> e, se Lawre		)		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. To provide the Tris marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	3	19a. Informant's Name/Relationship (Type, Print)	,	100	ng Address (Street a						
re, l	1 and 2 of Healt item 2 other		Jemell R. Green/Gra 20a Method of Disposition	20b. Pl	ace of Dispo	N. Monast		Date Date	20c. Location -			
timo	t. Page tment c tant: If tury or		1 X Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	From State Gar		natory or other place Forest		-15-12	Owings			
Ba	permir Depar Impor any ir		21. Signature of Funeral Service Licensee	us	52	Name and Addres	stersto	atman-H wn RD.	Harris Ralto.M	Fune.D.21	ralHome 215	
			23a. Part 1. Enter the disease, or complications t shock, or heart failure. List only one cause of	hat caused the death n each line.							Approximate Interval Between	
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	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
	e executed cian and ourial-transit		resulting in death) Last Due	to (or as a consequ	ence of):							
3760	ficate b g physi as the l	Medic	d							$\perp$		
Box 68760	ath certificate be attending physic for use as the bu	ian/	in the past 12 months?	outcome of pregnar Live Birth 2 ☐ Fetal Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	y		23d. Date Mor	e of deliver	y Day Year	
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s, P.O.	The law requires that the death certificate be ate has been signed by the attending physic page 2 should be detached for use as the b	þ	Part II. Other significant conditions contributing  Plabetes, Hypertension		-		en in Part I.		obacco use contri Ves 2 ☐ No		cause of death?	
ords	w requii s been 2 should	Completed	Property in the last of	1 Halpo H			~	24a. Was	an 24b. W	Vere autops	sy findings available	
Rec	nysician: The law nis certificate has t I director, page 2 s	Com						autor perfo	rmed? d	eath?	pletion of cause of	
Vita	ysician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2  Hospital:	☐ Inpatient 2☐ E	EB/Outpatien	Tothe	r: 4 Nursing	eck only one)  Home 5  Resid	dence 6 Cothe	r (Specify)	HOSPICE	
Division of Vital Records,	iing Ph .r. After thi funeral		27. Manner of Death 28a. D		28b. Time of injury	28c. Injury work	at		now injury occurre		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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2	e Hospital or Attending Physician: 24 hours after death 25 Funeral Director: After this certific letely filled in by the funeral director,											
	he Hos iin 24 hc he Fun ipletely	Medical	(Check 2   Medical Examiner: On the	basis of examination	and/or invest	igation, in my opinio	n, death occurre	d at the time, date a	ind place, and due	to the caus	se(s) and manner stated.	
	To the I within 2 To the I comple		29b. Signature and title of certifier	ND		29c. License			29d. Date signed			
	7,	- 1	30. Name and address of person who completed		23a) (Type, P				MARCH, O	1,20	,	
	Stat	-	DANTELLE CHERRICK MD 31. Date filed (Month, Day, Year) 3	2. Registrar's Signatu	ıre		more, 24	OI W. BE	LVEDERE,	BALTIM	ORE MD 21215	
	Registra	r	MAR 1 6 2012	tur &	pe	Kel				<del></del>		

12-02069 Robert V Greene Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2020868

		- For State Registrar		,		Certific	cate of	Death			J	Reg. No	0.	,	-	
Physicia	n/	Decedent's Name (First,	Middle,Las	st)							2. Date of D	Dav	Yea	_		of Death
Medical Examin		Robert			rnor	1		Green			March 1	12, 201	2			8 hrs
*	ľ	4a. Facility Name (if not in Sinai Hospital	stitution, giv	e street and n	umber)			b. City, Town, Baltimore		of Death		ľ	4c. County o	f Death		
Funeral		5. Social Security Number	6. S	ex	7. Age (Ir	n yrs. last bi	rthday)	If Under 1 Y	_	der 24Hrs.	8. Date of	Birth(MI	M/DD/YYYY	9. Birti Foreigi		State or
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Mar 28s	Director			_				10f. Zip Code				10g. C	itizen of Wh		try?	
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Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Ott 21. Signature of Funeral S					n-Si		se of Escili		0-12	Do	altim	016	, 140	u
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Physician	1:	23a. Part. Enter the disea	se, or comp	lications that o	aused the	death. Do n	ot enter th	00 Wab e mode of dyin	g, such as	cardiac or	respiratory	arrest, sh	nock, or hea	rt .	Approx	imate Interval
/Medical		faílure. List only one Immediate Cause (Final di		Contac	t Gun	shot 1	Mound	of Ho	n d					ĺ		en Onset and Death
£xaminer		or condition resulting in de		Due to (or as			иошца	OI HE	10							
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	<u>=</u>	if any, leading to immediate cause. Enter Underlying 0	ause	Due to (or as a	a conseque	ence of):										
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Box 68's death certificate attending and for use as	<u> </u>	past 12 months?	1	4 Pregr	nant at time	- 6 -111-		er (Specify)		o program	Ψ)		111011111	٥.	,	7 0 01
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending promplety filled in by the funeral director, page 2 should be detached for use as the	ᅀ	1 Yes 2 No 9	Unknown	a Cluku						2.200						
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Disafter in Div	セー	3 X Suicide 6 4 Homicide	Could not determined	pe		dence	,	, , ,				, State) 🤄	3503 S			le Ave.
Hospi 24 hou Funer rely fil		20a Cartifier	ng Physici	an: To the bes			ath occurr	ed at the time,	date and p					as state	d.	
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the				On the basis	of examina											)
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		Russell Alexande		Assistant N			900 V	V. Baltimor	e Street,	Baltimo	ore, MD 2	21223				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GRUTKOWSKI Physician/ C. MARCH 9:00 AM HARLOTTE Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care - Cherrywood Reisterstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Days 05/11/1935 Director 220-30-4238 1 □ M 2 🔀 F 76 Maryland Usual Residence of Decede 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Maryland Baltimore Randallstown 10e. Street and Number b 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a United States 8912 Maplebrook Road Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 X Never Married 2 Married 9 þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Court System 10 Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever ပ္ Martin Grutkowski Catherine Chojnowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17205 Whitely Road Monkton, Maryland 21111 Gary Lambrecht - Nephew 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I Important: If its any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 03/10/2012 Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility
Payid J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 Signature of Funeral Enter the disease mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. shock Interval Between ARTERY Onset and Death romediate Cause (Final 32A32iA OROMARY Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth ∠☐ Fregnant at time of death in the past 12 months?

1 Yes 2 No Day Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonny Sisens 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? death? 1 🗌 Yes director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Natural injury work? 1 Yes 2 No 5 Pending 2 Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and wile or centrie 29c. License number 29d. Date signed (Month, Day, Year) R088852

Registrar

IAMONA 2835

32. Registrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kn TH USSN

31. Date filed (Month, Day, Year)

2/20

/ANS

Smith Durace Concrisione Nomes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14:19 175 (3377) Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 432 S. Perrish St. Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) **Director** 1 □ M 2🏋 F Yrs. 01/04/1942 70 S. Carolina or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code must be r ò 10g. Citizen of What Country? Funeral 432 S. Perrish St. 21223 U.S.A. 2 should be filed who....
th and Mental Hygiene.
27 is marked other than "natural", or items...
...matic event, the Medical Examiner mi items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 XNever Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Janitorial ABM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Isaac Green Florence Holiday 19a. Informant's Name/Relationship (Type, Print) of Health 1203 Slaterd Brooklyn, MD 21225 Kelly Dickson(son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or or 1 Burial 2 🔀 Cremation 3 🗀 Removal from Stat on-site Crematory Baltimore, MD 4 Donation 5 Other (Specify) Josephadas of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 of Funeral Service Licensee 5 matur Part 1. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, deart failure. List only one cause on each line. erval Between Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to or as a consequence of cause. Enter Underlying that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): /Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a d be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 🖫 Sunknown Hospital or Attending Physician: The law requires Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify မှ After this of funeral direction 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after useum... se Funeral Director: After th' roletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature 29d. Date signed (Month, Day, Year) DO043371 who completed cause of death (Item 23a) (Type, Print)  $\mathcal{KTTM}$ )  $\mathcal{E934}$   $\mathcal{AVIATION}$ 

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Tarris Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Medical Center Belair Harford 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **Director** 57 212-62-6027 1 🛛 M 2 🗆 F 10-29-1954 Michigan Usual Residence of Decedent show. 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Maryland Harford Belair 1 Yes 2X No 10e. Street and Number ems 23a or r must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Coreopsis Court 21014 USA items 2 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: I item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and Mental Hygiene.
is marked other than "natural", or iter
aumatic event, the Medical Examiner 11. Marital Status 14, Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Safeway 12th Grade Meat Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maurice Harris Loretta Wiggleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherrie Harris/Wife 105 Coreopsis Court Belair, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greenmount Cemetery 3-21-12 Baltimore, MD. 21. Sign sure of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition MINUTE Medical resulting in death) Examiner 13 Vascul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last attending physician at for use as the burial Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year signed by the at d be detached for Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s Jas autopsy 1 Yes 2 No 1 Yes Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospita Other 1 Inpatient 2 ER/Outpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this Division of funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending s after dea... "al Director: After 1 Natural 5 Pending injury work? 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Plactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 10 9019 21014 ompleted cause of death (Item 23a) (Type, Print)  $\mathcal{O}\mathcal{O}$ MO 32. Registrar's S State Registrar

3/10/12

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1)800604501

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Medical reet and number) 4c. County of Death 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death Examiner Good Samaritan Nursing Center Baltimore 8. Date of Birth (Month, Day, Year) 03-26-1927 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Min. 1 🗆 M 2 🛣 F Days Hours Director 213-28-0562 Marvland Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1X Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ritems 23a or ner must be n Funeral 21212 716 E.Coldspring Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or iten ledical Examiner r Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Typist Administration 2Years t. Page 1 and 2 should be filed wit rtment of Health and Mental Hygie rtant: If item 27 is marked other njury or other traumatic event, tt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Florence Pennington Roland Oscar Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) E.Coldspring Ln.Baltimore, MD. 21212 Barbara Harris/Niece Department of Health Important: If item 27 any injury or other trong once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD. 03-19-12 Garrison Forest 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home MD.21215 5240 Reisterstown Road Balto. 23a. Part 1. Enter the disease, or complications that caused the death. o not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on s Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) us to (or as a nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA ည this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours af er dea h.

To the Funeral Director. Af completed filled ir by thε fu 1 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number drine se of death (Item 23a) (Type, Print) 30 Nam and Address of person who

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 1 per PHYS, G925, 3/22/2012, WS 19a
State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Claudia Hazlewood HAZELWOOD 2. Date of Death 3. Time of Death Physician/ CLAUDIA MARCH 15,2012 5:37 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 8000 NEIGHBORS AVENUE ROSEDALE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min 062-92-8657 **Director** 1 □ M 2 🔀 F 86 11-11-1925 **GUYANA** Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 XNo MD BALTIMORE ROSEDALE ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral **GUYANA** 8000 NEIGHBORS AVENUE 21237 **Examiner must** items death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo
If Yes, Give Black, White, etc and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify. Specify: GUYANESE 3X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ CLIFFORD COPPIN GOPPIE BEST 19a. Informant's Name/Relationship (Type, Print) DAUGHTER, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULA HAZELWOOD CHACWAUDIN Hazlewood Bhagwandin 8000 NEIGHBORS AVE 27 ROSEDALE, MD 21237 or other item 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-19-2012 CATONSVILLE METRO CREMATORY 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Fundamental Lice See 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ENSIGN Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner CHO WITERI 617 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and -tran: Due to (or as a consequence of) burial physician sthe buria Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) as attending IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 mor Month Dav Year Yes 2 No Unknown the thed g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò EMENTIA - MULTI INFARCT 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 **N**o ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, After this c funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work Μ 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral I Medical Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 18000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bally, MD21237 ARNI MI 1224 W. SOMMI 32. Rec State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Deatl 3. Time of Death Physician/ HAMILTON boom M Medical 4a. Facility Name (if no institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 214-56-6670 1 🗆 M 2 🕱 F 58 06 30 53 MD Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes 2 No MD NA Baltimore or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Examiner must be items 23a Funeral 2620 West Lafayette Ave 21216 U.S.A. death v . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 'natural", or 1 Yes 2 XNo Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than , Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the N llth Grade na Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph M. Hamilton Doris E. Johnson ye 1 and 2 should b t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2126 Doris Hamilton-Mother 2620 West Laffayette Ave, Baltimore, Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Zion 3/17/2012 Baltimore, Md 21. Signatu of Funeral Service Licenses March F/H West Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Physician Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Industry Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year 2 No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has perform Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Oth funeral 28a. Date of injury (Month, Day, Year) 27. Manner of De Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 D Accident 5 Pending injury Investigation 6 Could not be 1 Yes 2 No Suicide
Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type 93 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day HAROLD DENIS HORMES Medical MARCH-12 .2012 10:15A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS TIMONIUM BALTO. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. Days Director 219-38-7355 1 🕱 M 2 🗆 F 72 Yrs. MARYLAND 10-18-1939 Usual Residence of Deced ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location rector 10d. Inside City Limits MD. BALTO. KINGSVILLE 1 Yes 2 X No ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12005 CEDAR LANE 21087 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 1 Never Married 2X Married **X**Yes 2 □ No 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Specify: Completed 3 Divorced 4 Divorced WHITE event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **ADMINISTRATOR** LUMBER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HAROLD M. HORMES MARGARET MORNINGSTAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYLEE HORMES SPOUSE 12005 CEDAR LANE KINGSVILLE, MD. 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY GLEN BURNIE, MD. 3-16-2012 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause o at caused the death. Do not enter the mode of dying, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ebro disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of): attending physician the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death signed by the Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an 24b. Were autopsy findings available has autopsy perform prior to completion of cause of HORMES death? after death.

Director: After this certificate Yes 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HAROLD 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending injury 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitionur: To the best of my knowledge 29b. Signature and title of certifier 03-12-2012 meline 8×11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, 2300 DULANEY VALLEY ROAD CRNPTIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 6 2012 Registrar

27:01

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 2

AMEND TTEM# 26perpHYS, G925, 3/16/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 8, ^{Day}012 Hilker Jr. Edward William 11:07 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 3218 Wilson Ave.
5. Social Security Number 6. Sex Abingdon If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV • 22, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛂 M 2 🗆 F Months Days Hours 1963 Maryland 213-86-0860 48 Director Usual Residence of Decedent 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified 1 ☐ Yes 2 1 No Maryland | Harford Abingdon 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3218 Wilson Ave. 21009 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ "natural", or ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. I other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Carpet Store Carpet Layer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward William Hilker Sr. Carolyn Marie Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 3218 Wilson Ave., Abingdon, Maryland 21009 Carolyn M. Hilker / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State Oaklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3-12-12 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. any in 1317 Cokesbury Road, Abingdon, Maryland 21009 Fart 1. Enter the disease, or conshock, or heart failure. List on the ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ESO PHAGEAL disease or condition months Medical resulting in death) Due to (or as a consequence of) Examiner EPATITIS Sequentially list conditions, Be Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events 1PERTENTION burial-tran Due to (or as a consequence of) resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? CHREWIC 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

certificate be Box 68760 attending p ed by the a detached f P.O. 1 Hospital or Attending Physician: The law requires that the Records, page 2 s Division of Vital 24 hours after death. Funeral Director: Al сопретен within 2 To the I

and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

		Tours and V	D41080	03/08/-	2012-
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1.11.22	2 7 1 2	1101 21711
		ARCHANA SOOD, MD. 1208, E.	CHURCHVILLE Rd.	DELATE	Md. 21014
ate	е	31. Date filed (Month, Day, Year) 82. Registrar's Signature		-	
ra	r	MAR I U 2012 About B. Darker			

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) no lord sois

29c. License number

Registrar

only one) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Month Physician/ Keith Allan Harreld 3:17 P March 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 517 902 Garden Drive Essex 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Hours Min (Month, Day, Year) 311-76-1292 **Director** 1 **X** M 2 □ F 53 Dec. 31, 1958 Indiana Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Essex 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21221 USA Apt. 1A 902 Garden Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o, 1 X Never Married 2 Amarried Completed by 5-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White "natural" 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. 2121 Elementary/Secondary (0-12) 12 College (1-4 or 5+) Disabled Keith Horre Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roberta Elizabeth Emerick Floyd E. Harreld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Asher D. Harreld / Brother 706 Bradford La., Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State cemetery, crematory or other place, Rose Hill Svcs, LLC 3-14-2012 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosdorotic Onset and Death Immediate Cause (Final Physician/ douascular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of: if any, leading to infinediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 \( \text{Nursing Home} \) 1 Nursing Home 5 Residence 6 \( \text{Other} \) Other (Specify) 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at eral Director; After filled in by the funer work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certific 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) MD Trim 31. Date filed (I onth, Day, Year 32. Registrar's Signatur State 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 14^y 20°12 Alice Harris Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Bayridge Health And Rhabilitation Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Min (M047211928 ^{Co}Maryland 1 □ M 🏖 F 218-26-7533 83 Director Usual Residence of Dec 28a-f show aţ 10a. State 10b County 10c. City, Town or Location Director be notified MD Anne Arundel Annapolis 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **Examiner must** 900 Van Buren Street 21403 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give within 72 hours after 21215-0036 1 ☐ Yes 🎢 No Specify: Specify 3X Widowed 4 □ Divorced Black Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever and Mental I မ Unkn Unkn. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Fiore / Social Worker 4 East Rolling Crossroads, Baltimore, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial Ž Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 3/16/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed ysician and ne burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death Other (specify) ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Dementia Records, Completed Hypertension 24a Was an cate has l autopsy performed Yes 2 or Attending Physician: 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes X No Other: ۵ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division s after death.

I Director: After the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller of the fuller 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in within 24 hours a To the Funeral I To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) March 14, 2012

3. Time of Death

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Yes 2 No

A M

7:54

State Registrar 29b. Signature and title of

31. Date filed (Month, Day, Year)

MAR 1 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajit Kurup, M.D., 900 Van Buren Street, Annapolis, MD

32. Registrar's Signature

DHMH 17 Rev 06-2011

29c. License number

D006368

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State		artment of Hea tificate of Dea		, ,	2012	08179			
			Registrar  1. Decedent's Name (First, Middle, Last)		lineate of Dec		2. Date of Death					
	Physicia Medic			vey			Mar. 12,	2012 Year	1:50 A M			
	Examin	er	4a. Facility Name (if not institution, give street and number)  Gilchrist Hospice		4b. City, Town, or Loc	Towson		4c. County of Death	4c. County of Death  Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (	(In yrs. last birthday)			8. Date of Birth	g. Birth	place (State or Foreign			
	Director		123-16-3837 Usual Residence of Decedent	88 Yrs.	Months Days F		(Month, Day, Yea		York			
	and show dat	ξ		10c. City, Town or Loc	cation				10d. Inside City Limits			
	Mary 28a-f	Director	Md. Baltimore			onium			1 Yes 2 XNo			
	vith the 23a or st be r	ral	10e. Street and Number 2525 Pot Spring Road K404		10f. Zip Code	1093	10g.	. Citizen of What Cou USA	ntry?			
	items	Funeral	11. Marital Status  12. Was Decedent Eve Armed Forces?	er in U.S. 13. W	Vas Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spec	ify Yes or No-	14. Race - Ameri				
36	al", or	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【X No. 15 Yes, Give Year or Dates.	0	Yes 2 No S		iodii, otoly	Black, White, Specify:	White			
2-0	hours natur dical E	olete	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupation		16l	b. Kind of Business/Ir				
121	thin 72 ene. • than '	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)	life DC	O NOT use retired)	emaker	9	Ow	n Home			
<b>d</b> 2	il Hygid I <b>other</b> Vent, t	Be (	17. Father's Name (First, Middle, Last)				(First, Middle, Maid		n nome			
ylar	Ild be in Ments  narked narked	70	John Hannan				Helen	Murphy				
Mar	2 shouth and the and the and traum		19a. Informant's Name/Relationship (Type, Print)  Francis M. Harvey, Jr./Son		ng Address (Street and Cockeysvil							
re,	1 and of Heal of Heal		20a. Method of Disposition	20b. Place of Dispos				c. Location - City or T				
Baltimore, Maryland 21215-0036	ment trant: It tant: It jury or		1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Dulaney Va	alley Mem.							
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at one.		21. Signature of Funeral Service Licenses  Much and Much Angles	1	. Name and Address of 1050 York F	Road To	wson, Mar	Funeral H cyland 212				
E			23a. Part 1. Enter the disease, or complications that caused be shock, or heart failure. List only one cause on each line.			uch as cardiac or	respiratory arrest,		Approximate Interval Between			
	Phylician Medical		Immediate Cause (Final disease or condition resulting in death)  a. Deto (or as a condition or as a co	OWOW(	9				Onset and Death			
	Examiner	L	Sequentially list conditions, b.	onocquenco on.								
	ed sit	mine	if any, leading to immediate cause. Enter Underlying  Cause (Disease or injury	consequence of):								
	execute n and ial-tran	Еха	that initiated events resulting in death) Last  C. Due to (or as a continuous)	onsequence of):								
90	cate be executed physician and s the burial-transit	edical Examiner	d									
687	ertifica ding pl		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	pregnancy								
Box 68760	ss that the death certific gned by the attending p be detached for use as	Physician/M	in the past 12 months?  1 Live Birth 2  1 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	very Day Year			
	at the c d by the etache		9 Unknown  9 Unknown  9 Unknown	not resulting in the u	nderlying cause given i	in Port I	On Did to be a		h			
ds, P.	requires that been signed should be d	ted by	Part II. Other Significant Conditions Continuously to dearrout	The tresulting in the di			1 🗆 Yes	pacco use contribute to the cause of death?  es 2 No 3 Probably 4 Unknown				
Division of Vital Records, P.O.	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and lirector, page 2 should be detached for use as the burial-trans	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of			
tal	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?  Hospital:			of Death (Check o	-	NO TEL TES	2 11 110			
ίV	ding Physician: h. After this certific funeral director,	2	1 Yes 2 No Hospital: 1 Inpatient  27. Manner of Death 28a. Date of injury	t 2 ER/Outpatient	t 3 DOA Other: 2		ne 5  Residence	Other (Specify	nospice			
ouo	ending eath. rr: Afte he fune	ficate	1 № Natural 5 □ Pending (Month, Day, ) 2 □ Accident _ Investigation	Year) injury	work?	2 🗆 No	od. Describe flow ii	njury occurred				
Nisi	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (€	- At home, farm, stre 'Spec <i>ify)</i>	eet, factory, office	2.	8f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,			
0	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier Check Medical Examiner: On the basis of exam	y knowledge, death o	occurred at the time, da	ate and place, and	due to the cause(s	s) and manner as stat	ied.			
9	To the H within 22 To the F complete	Me	only one) 3 Certifying Nurse Practitioner: To the b	est of my knowledge,	death occurred at the ti	ime, date and plac	e, and due to the ca	ause(s) and manner as	stated.			
	F 3 F ŏ		· Alexandrus		DSE	7: 0 : -		Date signed (Month,				
7			30. Name and address of person who completed cause of deat  AMW A AMWES	th (Item 23a) (Type, Pr	(6701 N	J. Ch	rus s	March le	NMI)			
	Stat Registra		31. Date filed (Month, Day, Year)  MAR 1 6 2012	Signature San	W							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ? Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 139 Nor andal WRIT DI 20c Social Security Numbe If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday Country Virginia Min (MOTh/30/1966 224-08-3256 46 Director ` M 2 □ F 28a-f show 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 1X Yes 2 □ No MD Baltimore Randallstown 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4227 Huntshire Road 21133 **USA** death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4X Divorced Specify. Completed Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Correctional Officer 12 Local Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname t. Page 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked of 2 Henry Jenerette Naomi Gunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Drew / Brother 405 Randolph Street, Martinsburg, WV 25401 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 3/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a conseq ---- ce of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examir as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Other (specify) Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ ☐ g ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes ျ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Inpatient Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29b. Signature anahtitle of 29d. Date signed (Month, Day, Year, 05385 30. Name and address of person who completed cause of death (Item 2βa) (Type, Print) 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Angeline Physician/ Jerousek Jeannette 2:05PM 2012 March Medical 4b. City, Town, or Location of Death Dundalk4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 8319 Kavanagh Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Augus tear 214-40**-**1668 1 🗆 M 2 🔀 F **Director** 69 <u>Maryland</u> 22 1942 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 0a. State Director 1 Yes 2 XNo Dunda1k Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 21222 8319 Kavanagh Road death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 White If Yes Give Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Bookkeeper other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lisiewski Clara Adam Dziewanowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8319 Kavanaugh Road Dundalk, Maryland 21222 Lisa Izquierdo / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Maroh∘ Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 19,2012 St.Stanislaus Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA M00933 . Signature of Funeral Service Ligensee 1201 Dundalk Avenue Baltimore, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause Ertar Underlying Cause (Disease or injury discase Examin attending physician and for use as the burial-trar that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day in the past 12 months?

1 Yes 24 No 1 Yes 242 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed dependence 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? page 2 1 Yes 2X No Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home **SXX**Residence 6 Other (Specify) 28c. Injury at work? 1 Yes 2 No funeral . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending hours after death. Accident
Suicide Investigation n 24 hou... the Funeral Direc... ∵'v filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ceringing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number March 15, 2012 D 41399 Baltimore, Maryland 21224

DHMH 17 Rev 06-2011

State Registrar 30. Name and add

31. Date filed (Month

(Month, Day, Year) NAR 1 6 2012

Theodore Alexander Stephens, M.D. 1005 North Point Boulevard Ste724

ess of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 M 2 F Month, Day, Months Min. **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be northind to once. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marylan 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Countr Heights Funeral Park 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 No Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Williams esse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, ouise Moore -515tes 22WOOd 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City of Town, State 1 Burial 2 Cremation 3 Removal from State Lawn 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ba 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner (or as a consequence signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death page 2 should be detached g Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No After this certificate 1 Yes within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director director director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1) Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Rhetta Kentish 11:30aM Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince Georges Cheverly Prince Georges Hospital Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Days Hours Min 579-64-2379 64 **Director** /194 /16 District ofCol Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Washington DC 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 20019 ms 23a or must be r 10g. Citizen of What Country? Funeral 5000 Nannie Helen Buroughs Ave USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: black If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ed wit.

Al Hygiene.

Ad other the
c event, the Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetology Hair Dresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H item 27 is marked of other traumatic ever ပ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20012 Ann Vaughn - friend 6710 Piney Branch Rd. NW Wash.DC item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. Page 1 cemetery, crematory or other place) 1 \( \) Burial 2 \( \) Cremation 3 \( \) Removal from State 2/22/12 Riverdale Park 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Md. Signature of Funeral Service Licenses 22. Name and Address of Facility Universal Mortuary ash aru Kennedy S.t NW Wash 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or linjury the burial-transit that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death
Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year signed by the at d be detached for 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributin<u>g t</u>o death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 2 N Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 Tyes 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Marrier of De th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No atural ccident nours after death. Investigation the Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and little of certifie 29 c. License number 29d. Date signed (Month, Dav Near) ho completed cause of death (Item 23a) (Type, anatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First Middle | ast) 2. Date of Death ^{Day} **20**12 Physician/ MARCH 13, 9:30 PM CARSON **FORD** KREH, JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD BEL AIR ROYAL OAK DR. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) Director 217-80-0335 1 **X** M 2 □ F 52 July 11, 1959 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Harford Bel Air Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ō er than "natural", or items 23a of the Medical Examiner must be Funeral with 304 Royal Oak Dr. U.S.A. 21015 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Narried Completed by 2 X No Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Fuel Company 12 th. Grade Technician and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Kreh, Sr. Ruby Marie Carson Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s of Health If item 27 304 Royal Oak Dr., Bel Air Christine Kreh/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1  $\square$  Burial 2 X Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Department of Important: If any injury or once. 03/15/2012 Atlantic Crematory Glen Burnie MD 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Signature of Funeral Service Licensee Bel Air MD 610 W. Mac Phail Rd., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faithre. List entry one cause on each line. Interval Between Onset and Death Immediate Cause Line netastas Physician. disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Elter Underlying Cause (Disease or injury Due to (or as a consequence of) and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 110 1 Yes Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the To the To the 29b. Sig ture and title of certifier 29d. Date signed (Month, Day, Year) March 14th 2012 address of person who completed cause of death (Item 23a) (Type, Print) 520 Upper Chesapocake Drive # 409, Bel Air, MD 21014 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 26, per phy, g925 3-16-12 sm State of Maryland / Department of Health and Mental Hygiene 20 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 Physician/ 8:15 au WILLIAM S. KOSICKI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE QUAIL RUN ASSISTED LIVING PARKVILLE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 195-20-2955 86 **1**X□ M 2 □ F Yrs. PA 12/9/1925 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 ☐ Yes 2 No MD PARKVILLE 10f. Zip Code 21234 10g, Citizen of What Country? 10e. Street and Number J Hygiene. I other than "natural", or items 23a or went, the Medical Examiner must be r Funeral 9900 WALTHER BLVD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married X Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BALTO. CO. SCHOOLS MATH TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ....... rage 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumating once. မ HELEN O'KONSKI STANLEY KOSICKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6825 CAMPFIELD RD APT 10J BALTIMORE; MD: 212344 19a. Informant's Name/Relationship (Type, Print) APT 10J 6825 CAMPFIELD RD BERNADINE KOSICKI-WIFE 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State GARDENS OF FAITH 3/13/12 BALTIMORE, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIFFEL FUNERAL HOME, INC neral Service Licensee BALTIMORE, MD 21206 6415 BELAIR RD Part 1. Inter the disease, or complexations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and after the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death cate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by NSTEMI 1 ☐ Yes 2 Д No 3 ☐ Probably 4 ☐ Unknown Completed bladder cancer 24a. Was an 24b. Were autopsy findings available HIJTOU prior to completion death? performed 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home -5-12 R 6X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONSINT BUTER 31. Date filed *(Month, Day, Year)* **MAR 1 6 2012** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lawton 1:004 M Vickie Lynn 2012 Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number Sage Court, Apt. 4b. City, Town, or Location of Death **Examiner** Court, Apt. Pikesville . Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Hours (Month, Day, SC Director 1 M 2 X F 1961 17 28a-f show 10d. Inside City Limits 10c. City, Town or Location Director Examiner must be notified Baltimore MD PIKESVITE 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Court, Apt. C Funeral than "natural", or items 23a 1 Sago 212013 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify. Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Mental Figure 27 is and Figure 27 is marked other than any injury or other traumatic event. the Mental Experiment Street Laidlaw Bus Driver 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Henry Bates, Jr. Davis Lawron, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sage Court, Apt. C. (Mother) Pikesville MD 21208 Annie B. Derr 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Piedmont, SC Resthaven Mangardens 03 20/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Everne Funeral Sonles 21. Signature of Funeral Service Licensee Vaud Kandallstown MD 21133 Road 23a. Part 1. Enter the o shock, or heart fai sease, or complications that caused the death. Do not enter the mode of dying, susplas cardiac or respiratory arrest Onset and Death Immediate Cause Fina disease or condition Phynician/ disease or condition resulting in death) a 0 Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month the Unknown P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has Yes 2 No 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fi M Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0020964 March 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pikesville, MD 21208 Suite 202 1100 Reisterstown Road Jerome H. Ginsberg, M.D.31. Date filed (Month, Day, Year) State MAR 1 6 2012 Registrar

12-02143	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

	hard Linthicum Jr.	2. Date of Death Month E March 14, 2	Day Year	3. Time of Death
			012	2033 hrs
4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death	
1400 Henryton Road  5. Social Security Number   6. Sex   7. Age (In year)	Marriotsville  rs. last birthday)   If Under 1 Year   If Under	24Hrs 8 Date of Birth	Howard (MM/DD/YYYY) 9. Birth	place (State or
Director 217–56–4868 _{1∑M 2□F} 5	Months Days House	Min. 07/18/1	` Eoroian	
Howard	City, Town or Location Columbia			10d. Inside City Limits
10e. Street and Number  5430 Lynx Lane #284  11. Marital Status  12. Was Decedent Ever in Armed Forces?  Armed Forces?	10f. Zip Code 21044	10g	. Citizen of What Count USA	try?
- S y all y l l l res ∠k l N	If Yes, specify Cuban, Mexican,		14. Race - Americ White, etc.	
a Widowed 4 Divorced If Yes, Give Yeer or Dates:  15. Decedent's Education (Specify only highest grade completed by the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the proper	d) 16a. Decedent's Usual Occupation (Give during most of working life. DO NOT		16b. Kind of Business/In	dustry
900 20 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Business Owner		Private	:
T2 T2 T2 T2 T2 T2 T2 T2 T2 T2 T2 T2 T2 T		s Name (First, Middle, Ma ean Cavey	aiden Surname)	
Jane Sachs (Ex-wife)	19b. Mailing Address (Street and Num 6273 Audubon Driv	e, Columbia	MD 21044	1
20a. Method of Disposition  1	Ob. Place of Disposition (Name of cemetery, crematory or other place)  Ardent Cremation	Date 3/16/2012	20c. Location - City or T Hanover, M	
TWO DUCKES !	22. Name and Address of Facility 2818 E. Baltin	ore STreet,	Baltimore	MD 21224
Physician  23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.	eath. Do not enter the mode of dying, such as c cide Intoxication	ardiac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  a. Carbon Monox  Due to (or as a consequent)				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ice of):			
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23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic	c pregnancy	23d. Date of delivery Month D	ay Year
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Suicide    Accident   Accident   February	2 fd 8:15 pm 1 Yes 2 X At home, farm, street, factory, office building, et esidence	tc. 28f. Location (St or Town, Sta	treet and Number or Ru ate) 1400 Henr	yton Rd.
29a. Certifier (Check only 1 Certifying Physician: To the best of my kno	wledge, death occurred at the time, date and plaction and/or investigation, in my opinion, death oc	ace, and due to the cause	e(s) and manner as state and place, and due to the	ed.
one) 2 Medical Examiner: On the basis of examinat and manner stated.  29b. Signature and title of certifier	29c. License number	OCME	29d. Date signed (Mor	nth, Day, Year)
30. Name and address of person who completed cause of death. Theodore M. King, Jr., MD. Assistant Medic	(ftem 23a) cal Examiner 900 W. Baltimore Str		March 15, 2012 	·
State 31. Date filed (Month, Day, Year)  Registrar  NAP 1 6 2012				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29c per verb., 9925,03/16/2012dhb
State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend Item 25 per me, g925,03/15/2012dhb, 23a
Reg. No. 2 | 2 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Lewis PM 45 Physician/ 2012 Marc evin Medical 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death 4a. Facility Name ( **Examiner** Medical Baltimore Cente If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Numbe **Funeral** (Month, Day, Year) Days Hours Min. Country) 1 M 2 □ F **Director** Usual Residence of Decedent lod. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County must be notified at Director 1 ¥ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number o 23a Funeral .S.A TANE Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Black, White, etc. Armed Forces' ō þ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 ☑ No Specify: permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give 3 🗌 Widowed 4 🗌 Divorced "natural" Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) AUTO PARTS SI Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ LARIES L 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RMANTOWNHD. 20874 DEVENISH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State OTENION, MO. 3-18-12 4 ☐ Donation 5 ☐ Other (Specify) JOHERTY FUNERAL HOME Signature of Funeral Service 22. Name and Address of Facility 2601 MOUNTAIN RO. PASADENA, MD. Z112Z Approximate Interval Between Onset and Death ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or con shock, or heart failure. List any one cause on each line. Complications of Diabetes Immediate Cause (Final [™]Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of CERTIFICATION APPRINTED FOR THE BOOK TO THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE Examiner POXICA Sequentially list conditions, Due to as a consequence of): Examiner that y leading to immedia cause, Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Month Dav in the past 12 months? 5 Other (specify) Pregnant at time of death ed by the a Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown iabetes 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has performed 1 Yes 2 No After this certificate 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 1 X Yes မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: injury work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Acciden Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director: 6 Could not be Z Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29c. License numbe P27234 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier မ 2012 March 1461131610 and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Greene timore Andrew eman 31. Date filed (Month, Day, Year) 37. Registrar's Signature State MAR 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Montl Physician/ 2012 Robert Elmer Loehe 12 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) Funeral Days Hours Months **Director** 390-26-9352
Usual Residence of Deced 1 🕱 M 2 🗆 F 80 Sept.27,1931 Wisconsin iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9731 51st Avenue 20740 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was Decedent Ever In U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.1948—83 Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", Completed 3 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Colonel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Department of Health and Ment Important: If item 27 is marke any injury or other traumatic Joseph Loehe Elsie Zielke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Susan Levy / wife 9731 51st Avenue College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/17/12 Final Journey Crematory Woodbine, MD 21. Signature of Faneral Service Licensee. 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M lever 19 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Dementia, Atrial Fibrillation, Failure to thrive Records, 24a. Was an autopsy performed? Yes 2 K No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital 1 Yes 2 X No မ 1 Mainpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No ë 28d. Describe how injury occurred To the Hospital or Attending injury X Natural 5 Pending Certifica Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) 29a. Certifier Macertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ■ (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 🗆 No 28f. Location (Street and Number or Rural Route Number 29d. Date signed (Month. Day, Year) March 14, 2012 MD 1500 Forest Glen Road Silver Spring, MD 20910

2057

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 X Yes 2 No

State Registrar

6x1

Norusse

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yodet Nefusse,

31. Date filed (Month, Day, Year)
MAR 1 6 2012

29c. License number

D0069288

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Lathe March 2012 4:50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3405 - 4th Street Baltimore N/ASocial Security Number 7. Age (In vrs. last birthday) If Under If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Months Days Min. (Month, Day, Year) Hours 212 78 2344 **Director** 53 07/13/1958 Usual Residence of Decedent Maryland show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland N/A Baltimore 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. 'is marked other than "natural", or items 23a or 'aumatic event, the Medical Examiner must be r Funeral 3405 - 4th Street 21225 U.S. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Late 15-0036 can be should be filed within 72 hours after compartment of Health and Mental Hygiene. Important: If item 27 is marked can any injury or other 1 Never Married 2 X Married þ If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Northrup Grumman 12th Missions Systems Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Combs Theresa Lowry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lathe Jr. / Husband 3405 - 4th Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 03/19/2012 4  $\square$  Donation 5  $\mathbf{x}$  Other (Specify) EntombmentCedar Hill Cemetery Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that cauded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a mach line. Interval Between Onset and Death Immediate Cause (Final hysician disease or condition Medical resulting in death) ears Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death the g Unknown þ signed It Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsv death? certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after death.

e Funeral Director: After th
pletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely . within 2, To the F complet only one) Certifying Nurse Practitioner: To the best of my kr eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Ludemam, William Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 628

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	Please Type or Print in Black Indelible Ink. Ensure Al Copies Are Legi State of Maryland / Department of Health and Mental Hygiene Certificate of Death							ZUI	2 0	819			
		Decedent's Name	e (First, Middle,	Last)			tirrodito or E	-	2. Date of D	Death			of Death
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Examir	ner	4a. Facility Name (if		give street and num. ake Medic	,	4b. City, Town, or Location of Death  Bel Air				4c. County of Death  Harford			
Funeral		5. Social Security Nu	-		7. Age (In yrs.		If Under 1 Year	If Under 24 Hr			9. B	irthplace (State	or Foreign
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Mary 28a-f	Funeral Director	Maryland		ord		Bel Aiı						1 🗆 Y	es 2 No
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na					ng Address (Street a						
and 2 Health tem 23		Betty J.  20a. Method of Disp		n / wire			Locust La						
permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tranonce.			Cremation 3	Removal from s	State <b>Gar</b>		Forester Ve Cem	TToo	21 [⊡] 2012 <del>k-</del>	Owi	ocation - City on the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of the City of	s, MD	
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or Attending Physician: The law requires that the death certificate be executed after death.  Jare death.  After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d									_		
certific nding use as	N/M	IF FEMALE: 23b. Was decedent p	oregnant	23c. If yes, outc	ome of pregna	ncy	1 -				23d. Date of de	elivery	
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To the Hospital or Attending R within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1	Certifying P	hysician: To the be	st of my knowl	edge, death o	ccurred at the time,	date and place	and due to the	cause(s) a	nd manner as s	tated.	
the H thin 24 the F omplete			☐ Certifying N	miner: On the basis urse Practitioner:	To the best of n	ny knowledge,	death occurred at the	e time, date and	place, and due to	the cause	e(s) and manner a	as stated.	anner stated.
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7		30. Name and addres		o completed cause	of death (Item					/*10	arctt o	1,00	
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Stat Registra	e ir	31. Date filed (Month,	AR 162	012 32 Rec	gistrar's Signat	. Sa	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dyr g925 3-16-12 yt State of Maryland / Department of Health and Mental Hygiene AMEND ITEM# 30perDVR, G925, 3/16/2012, WS

Certificate of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14, 2012 John George Luber 7.35 P March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 213-20-7264 1 X M 2 D F 86 Yrs. Maryland Usual Residence of Decedent show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 No Maryland Anne Arundel Glen Burnie ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral filed within 72 hours after death with Americana Circle #104 21060 United States ural", or items ? I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 X Yes 2 No 1 Yes 2X No Specify. If Yes, Give Specify: White "natural", 3 Uidowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Board of Directors Credit Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve marked ဂ္ John C. Luber Helen Agnes Lying 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores P. Luber/Spouse 7839 Americana Circle #104, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill 03/20/2012 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Straice Licers 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home
421 Crain Highway SE, Glen Burnie, Maryland 21061 B 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ MDR SIS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Rencarbi burial-trar and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy
5 Other (specify) ____ for Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available autopsy prior to completion of cause of death? 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မ within 24 hours after deaun.

To the Funeral Director: After this completely filled in by the funeral di Inpatient 27. Manner of Death
1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Accident injury work? Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) at Do HUUJOY8L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keith Goulet 600 Ridgely Ave Ste. 121 Annapolis, Md 21401 1 6 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # 1 Per PHY G925 3/16/2012 IH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Dorothy C. Matheny Month 5.00 2017 MAI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death n/a GOOD SAMARITAN NURSING BALTTMORE HOME If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2 X 03/23/1923 88 MARYLAND **Director** 219 18 2301 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the M diral Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD BALTIMORE ROSEDALE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 713 CHESACO AVE 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 C&P TELEPHONE TELEPHONE OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOHN R. VITEK ELIZABETH R. CVACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY J. MATHENY/HUSBAND BALTIMORE, CHESACO AVE MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) GARDENS OF FAITH 3/16/12 BALTIMORE, MD Signature of Ineral Service 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME CHESACO AVE BALTIMORE, MD 21237 1211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician as disease or condition Medical resulting in death) Due to (or as a consequence of) Houth Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No Month Day Year Pregnant at time of death 5 Other (specify) Unknown g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No Yes 2 No 1 Yes director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) It 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) () limble. 31. Date filed (Month, Day, Year) State MAR 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, AMEND TTEM#18perFH. G925, 3/22/2012 WS State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARIE PATRICIA MAREK 2012 MARCH 14 1:00 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1809 PUTTY HILL AVENUE BALTIMORE PARKVILLE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 213-30-0521 78/rs. 1 🗆 M 2 🕱 F 3-16-1933 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits BALTIMORE PARKVILLLE 1 Tes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1809 PUTTY HILL AVENUE 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER 12 GRADE SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY GREENSFELDER KATHERIVE 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH P. MAREK, JR/SON 10411 BALSAMWOOD CT LAUREL, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3-17-2012 BALTIMORE, MD ☐ Donation 5 ☐ Other (Specify) OF FAITH 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death UTEDINE

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Physician/

Medical

10a. State

MD

**Examiner** 

**Funeral** 

**Director** 

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items 23a

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Page 1

must be notified at

Director

Funeral

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Completed

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Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate I

Records, P.O. Box 68760

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Н	resulting in death)	Due to (or as a consequence of):							
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	resulting in death) Last	Due to (or as a consequence of):							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23d. Date of delivery Month Day Year							
þ	Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 Unknown					
Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 🚺	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2 No					
Be	25. Was case referred to medical	26. Place of Death (Chec	k only one)						
10E	1 L Yes 2 ANO	ospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 Other (Specify)					
Certificate:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day, Year)  28b. Time of injury  28c. Injury at work?  1  Yes 2  No	28d. Describe how inju	ury occurred					
	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)					
Medical	(Check 2 Medical Examine	cian: To the best of my knowledge, death occurred at the time, date and place, a ar: On the basis of examination and/or investigation, in my opinion, death occurred at Practitioner: To the best of my knowledge, death occurred at the time, date and place.	t the time, date and place	e, and due to the cause(s) and manner stated					

29d. Date signed (Month, Day, Year)

Registrar

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month () 2 Physician/ MCCRAY RICHARD 04:17AM 2012 Medical 4a. Facility Name (If not institution, give street and number)
University of Maryland Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore (enter If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** -64-1146 Country) Director 1**X** M 2 □ F 101 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21060 Loa 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry Un Kwn (Specify only highest grade completed) (Secondary (0-12) abover Be 17. Father's Name (First, Middle, Last, Mother's Name (First, Middle, Maiden Surname) Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Hicility March FIH-East 1101 E. North Ave. MO 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Infarction Muccardial Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 🗹 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed Yes 2 death? 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 🗹 No 1 Yes မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 1275822876 03/13/12 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ligeiro, 22 S. Greene St Baltimas, MD 32. Registrar's Signature 31. Date filed (Month, Day 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2 - State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Johns Hopkins Hospita 1timore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min (Month, Day, Year) 219-52-2900 Usual Residence of Decedent **Director** 64 1 - M X F 14 47 MD 06 the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No Baltimore NA 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a jury or other traumatic event, the Medical Examiner must be Funeral U.S.A. 21213 1693 Darley Ave 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Senior Aide Adult Center 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cina Hughes James Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Eva Ct., Middle River, Md 21220 Morey Morris-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Arbutus Memorial 3/17/2012 Arbutus, Md e of Funeral Service Licensee 21. S d March F/H We 4300 Wabash est Ave, 21215 Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 X Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider 3 Suicide injury 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title-of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 201 0 gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St Baltimore Maryland 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible, amend 26, per phy, 8925 3-16-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marquardt Month Year Dolore S 7:18P M 2012 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5124 McFAUL RD ROSEDALE BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth Hours 1/24/1923 Director 218-12-7074 89 MD 1 □ M 2**X**□ F Usual Residence of Decedent show. 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MDN/A BALTIMORE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be r Funeral 4515 PARKMONT AVE 21206 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LOWELL FLETCHER MARGARET ANNA WILSON Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $5124\ McFaul\ RD\ BALTIMORE$ , MD 21206SUSAN COBURN-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BEL AIR MEMORIAL GDNS 4 ☐ Donation 5 ☐ Other (Specify) 3/10/12 BEL AIR, MD 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMROE, MD 21206 23a (Part ). Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause of each tine. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Atheroscierotic Cardiavascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death
Unknown 9 Unknown β signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 🗖 No Other: ျ 4 Nursing Home 5- Residence 6 M Other (Specify) Daughter 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? n 24 hours after death.

e Funeral Director: Affoletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mskajapahremin DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Rajapaksemb Baltomore MD 21209. 2835 Smin AV 5703 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 14,2012 14:10 SALVATORE J. MAGGIO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD UPPER CHESAPEAKE HOSPITAL BEL AIR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours **Director** 213-12-3578  $90_{\rm Yrs}$ MARYLAND JUNE 4,1921 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. BALTO. **ESSEX** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral USA 21221 601 RIVERSIDE DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - Anc...
Black, White, etc.
WHITE 14. Race - American Indian, à 1 Never Married 2 XMarried Maryland 21215-0036 If Yes, Give Year or Dates. 1942–1945 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CLERK U.S. POSTAL OFFICE UNKNOWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY CHARAMONTI SAMUEL MAGGIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4702 GREEN COVE CIRCLE BALTO. MD. 21219 permit. Page 1 and 2 sh.
Department of Health an
Important: If item 27 is
any injury or other trau DTR. DONNA THOMAS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 3-17-2012 BALTO. MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTO.MD. 21224 23a. Part 1. Enter the dis , of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failue. Lief only one cause on each line. Immediate Cause (Fig. 5) Onset and Death Physician/ disease or condition resulting in death) Medical Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: ase s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? 2 3 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work 1 Yes 2 No 2 Accident Investigation after death filled in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 Gertifying Nurse Prantitioner: To the best of my knowledge, death 29b. Signature and title of certifie D60768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pper ciresapeake Drive Bei Air MD 21014 rmo 500 l Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Ph_sician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

for State Registrar

10a. State

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

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23a

, or items

"natural"

the Medical

Examiner must be notified at

Director

Funeral

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Completed

Be

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within 72 hours after death with the Maryland

signed by the a d be detached f

filled in by the funeral

29b. Signature and title of

31. Date filed (Month, Day,

within 24 hours a To the Funeral L Tpletely

Division of Vital Records, P.O. Box 68760

disease or condition resulting in death)	a. Due to (or as a consequence of):	Posts
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last	c	
	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify) 9  Unknown	23d. Date of delivery  Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4
		24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2  No
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
1 ☐ Yes 2 ŪNo	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Hor	ne 5 Residence 6 Other (Specify)
27. Manne Death  1	tition (Month, Day, Year) Injury work?  M 1 Yes 2 No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 L Medical Exa	Physician: To the best of my knowledge, death occurred at the time, date and place, an aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are the property of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.	the time, date and place, and due to the cause(s) and manner state

State Registrar

who completed cause of death (Item 23a) (Type, Prin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕕 📙 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Estelle Rose Millner 736 AM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimor Ey Baltim Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 - M 2X F Days Hours Min. (MO6)/ P4/1946 214-44-5158 65 ColMaryland **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director t Yes 2 ☐ No MD Baltimore Windsor Mill 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7904 Dunhill Village Circle, Apt. 103 21244 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 22 No
If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event the Marked. þ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Holt, Sr. Rosalie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nedra Kim Millner / Daughter 7904 Dunhill Village Circle, Apt. 103, Windsor Mill, MD 21244 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Chesapeake Crematory 3/17/2012 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ulmonary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown detached Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 Hospital or Attending Physician: The 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medica Vital 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) ပ္ 1 Inpatient 2 FR/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No 2 Accident Investigation 24 hours after deatl Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c, License number 0054452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17/ Hospital of Baltimore · Cinley a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2012 Registrar

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AS.

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		For State Registrar	State of Maryl		irtment of F tificate of D			giene Reg. No. 201	2 08201
Physicia	ın/	1. Decedent's Name (First, Middle, La.	,				2. Date of Dea	ath	3. Time of Death
Medic Examin	al	Teresa Isabel Sa  4a. Facility Name (if not institution, give			4h City Town or	Location of Death	March	11, 2012 Year 4c. County of De	5:29AM M
Examile	er	Hebrew Home	3 3 3 3 3 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4		Rockvil			Montgon	
Funeral		Social Security Number     6. S		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h 9. E	Birthplace (State or Foreign Country)
Director		081-24-4360 Usual Residence of Decedent	□ M 2 💢 F	Yrs.			October	15, 1921 Pu	erto Rico
yland f shor	ctor	10a. State 10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limits
ne Mar or 28a notifi	Dire	Maryland Montgom	nery R	oĉkville	10f. Zip Code	E CAR		10g. Citizen of What 0	1 X Yes 2 No
with the s 23a c	Funeral Director	6121 Montrose F	Road #597		20852			United St	
death • items ner m		11. Marital Status	12. Was Decedent Ever in Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		nerican Indian,
s after ral", or	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates.	1	X Yes 2 □ No	Specify:	rto Rica	Specific	
"natur	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	ent's Usual Occupa ind of work done d	ation		16b. Kind of Busines	nite ss/Industry
ithin 73 ene. • than he Me	Som	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Ìife. DC	NOT use retired)	anny most of work	9	National of Health	Institutes
idnical KIKI 12-0030 be filed within 72 hours after death with the Maryland wind lygiene. And all-lygiene. Cevent, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	J <del>T</del>	SCIE	ntist	18. Mother's Nam	ne (First, Middle,		<u> </u>
ylal Id be f Menta arked atic ev	욘	Jose Sauri Trista	ani			Josefa N	Mercado		
ite, INTAILYIALLY ZICIOOOO  I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  I manked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	1 8	19a. Informant's Name/Relationship (7						; City or Town, State, 2	
f Healt f Healt item 2 other		Glenna May Hendri 20a. Method of Disposition		b. Place of Dispos	sition (Name of		cfax, Vi	rginia 220 20c. Location - City	
Page nent c		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, crem Sate Of Heave	natory or other place n Cemeter	Mar	ch 2012	Silver Spi	ring, Maryland
partilling permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licen-	See /	22. Bo	Name and Addres	s of Facility Rol	pert A.	Pumphrey F	Cuneral Home/ consin Avenue
<u> </u>	1/2	23a. Part 1. Enter the disease, or con-	MOO MOO	335 Be	thesda.	Maryland	20814-3	501 "130	Approximate
Ph_sician/		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.			,,	er reepitater, air		Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	a. Cerebral  Due to (or as a cons		18				
LAGIIIIICI	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	oduoneo ofi:					
nted d ansit	Examiner	cause. Enter Underlying Cause (Ulsease or Injury that initiated events	Bue to (or as a cons	equence on,					
e executed cian and ourial-transit		resulting in death) Last	Due to (or as a cons	equence of):					
Attending Physician: The law requires that the death certificate be a death. After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the but	Physician/Medical		d						
certific inding use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-					23d. Date of c	lelivery
that the death cred by the attented for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		Other (specify)	у		Month	Day Year
at the ed by t		g ☐ Unknown  Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
uires th	ed by	Hypertension					1 🗆 1	/es 2 <b>X</b> No 3 □	Probably 4 - Unknown
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sician: The lar certificate har irector, page 2								med? death?	
ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital: 1  lnpatient 2	□ EB/Outpation	Otho	r: KZ		0 T Other (O	
ding Phy h. After this funeral of		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year,	28b. Time of	28c. Injury	at		ence 6 Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other (Special Other Other (Special Other Other (Special Other Other (Special Other Other Other (Special Other Other Other Other Other Other Other (Special Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Ot	эсігу)
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al or Ai s after Direc		4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe		et, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
To the Hospital or Attendinive Within 24 hours after death.  To the Funeral Director: After Completely filled in by the fur	Medical	(Check 2 Medical Exam	sician: To the best of my kn iner: On the basis of examina se Practitioner: To the best	ation and/or investi	gation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due to the	e cause(s) and manner stated.
To the within To the comp	2	29b. Signature and title of certifier	000		29c. License			29d. Date signed (Mor	
		Dines	-	MD	D0018	3084		March 11,	2012
		30. Name and address of person who		, , , , ,	,	illo Mor	evland o	0852	
Stat		Dinesh Patel, M. 31. Date filed (Month, Day, Year)	2. Registrar's Sig	nature 1.	u, RUCKV.	rire, Mai	yranu Z	0072	
Registra		MAR 1 6 201	2 P. Registrar's Sig	a. yar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 4014 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 Physician/ Month Joyce K. Melonas 12:10 PM March 14 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Timonium Stella Maris Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 215-12-9119 92 West Virginia Director 1 M 2 XF 7/10/1919 Usual Residence of Deceden 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21093 41 Merrion Court 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thelma Boyadzis Ernest Karas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merrion Court Timonium, Maryland 21093 Mitsie Doccolo / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cem. 3/17/2012 Woodlawn, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final On ot and Death Ph_sician DEMENTI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and -trans Due to (or as a consequence of) use as the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. performed 2 🗌 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) MELONAS 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Meritying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DCRNY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM MD31. Date filed (Month, Day, Year, 32 Registrar's Signature State MAR16 Registrar

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		1 _ State	of Maryland / Dep	partment of Healtr artificate of Death			2016	2 08203
		Registrar  1. Decedent's Name (First, Middle, Last)	Ce	runcate or Death	<i>'</i>	2. Date of Deat	eg. No.	3. Time of Death
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Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 F	7. Age (In yrs. last birthday) 7 4 Yrs.	Months Days Hours	ler 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year) 37 Rox R	hplace (State or Foreign
D W		Usual Residence of Decedent						
arytand a-f sh fied a	cto	10a. State 10b. County  FREDERICK	10c. City, Town or Le					10d. Inside City Limits 1 ✓ Yes 2 ☐ No
the Ma or 283	Dir	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	
s 23a	Completed by Funeral Director	355 MONTEVIEW LN		2170	12		USA	
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be fill lental rked c	၉	CHARLES LEE NORW	000			E MAS		
should and N is ma aumal		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Num	ber or Rura	l Route Number,	City or Town, State, Zip	Code)
and 2 seeith		CHARLOTTE WHIMS		1 QUINN ORC	1tvtRi)			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 We Burial 2 Cremation 3 Removal from	20b. Place of Disp cemetery, cre	ematory or other place)			20c. Location - City or FREDERICK	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician: To the la (Check 2 Medical Examiner: On the base) 3 Certifying Nurse Practioner:	isis of examination and/or inve	stigation, in my opinion, death	occurred at	the time, date and	d place, and due to the c	ause(s) and manner stated.
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08		30. Name and address of person who completed cau	1 801 Tal	i House Av.	e	Sede	4 HO 2	1701
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Day	Medi	cal	Harry Lee Nagle J						arch 13,	
	) Examir	ner	4a. Facility Name (if not institution, give stree Stella Maris Hosp	4b.	4b. City, Town, or Location of Death  Lutherville			4c. County of Death  Baltimore		
	Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. last	114-	Under 1 Year	If Under 24 Hrs Hours Min	8. Date of Birl	th	Birthplace (State or Foreign
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	land show dat	호	10a. State 10b. County	10c. City,	Town or Location	n			<u>-</u> -	10d. Inside City Limits
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	eath w	<b>Funeral Director</b>	11. Marital Status 12.	Was Decedent Ever in U.S.	13. Was [			pecify Yes or No- to Rican, etc.)		- American Indian,
л. 36	after d ", or i	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		, specify Cubai Yes 2 <b>□≤</b> ∫o		to Rican, etc.)		K, White, etc.
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2012 arylar	hould and Mi is mar		19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailing Ad	dress (Street a	nd Number or Ri	ıral Route Numbe	r, City or Town, St	ate, Zip Code)
.3° .≅ ∑.	1 and 2 should be of Health and Ment fitem 27 is marked rother traumatic e	١,	Lee Westerman /Fre			Sandhil	ll Rd.	Essex, M	D 21221	
MARCH 13 Baltimore,	Page 1 a ment of H ant: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	noval from State cen	ce of Disposition metery, cremator	y or other place		Mar 15		City or Town, State
MARCH 3altimo	permit. Page 1 a Department of F Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		sapeake	ne and Addres	s of Facility	2012		ville, Maryland
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	that the ned by the detach	y Ph	Part II. Other significant conditions contrib	uting to death but not result	ting in the underl	ying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
	requires t been sign should be							1 🗆 🕆	Yes No	3 ☐ Probably 4 ☐ Unknown
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of Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ital:	2/0-1	Othe	ce of Death (Che			
of \	ig Physical this neral di	te: To	27. Manner of Death	1 Inpatient 2 EF 28a. Date of injury (Month, Day, Year)  28	8b. Time of injury	28c. Injury	at		lence 6 X Other ow injury occurred	(Specify) HOSPICE
ion	tendin leath. or: Aff the fui	ifica	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Worth, Day, Tear)	N N	work?	res 2 No			
Division	or At after c Direct I in by	Certificate:	4 Homicide determined	8e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fa	actory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician	To the best of my knowled	lge, death occur	red at the time,	date and place,	and due to the ca	use(s) and manne	er as stated.
4)	the Ho nin 24 the Fu nplete	Mec	only one) 3 X Certifying Nurse Pro	On the basis of examination are still ones. To this best of my	ind/or investigatio	n, in my opinior	n, death occurred	at the time, date a	nd place, and due	to the cause(s) and manner stated.
	Norith Cor		29b. Signature and title of certifier	<b>X</b> 440 0		29c. License	number		29d. Date signed	(Month, Day, Year)
	mol		30. Name and address of person who compl	eted cause of death (Item 2)	3a) (Type, Print)	N5(	10		4/13	19013
-	10,		TRACIE L. MORGAN,	CRNP 2300 DI	III ANEV V	ALLEY	RD. TII	ONIUM.	MD 21093	
1	Stat	e	31 Date filed (Month Day Year) NAR 1 6 2012	32. Redistrar's Signature				15%		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - State Registrar Certificate of Death 2. Date of Death Physician/ K NGUYEN 4:05 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNIVERSITY OF MARGILAND MERICAL CENTER BAUTI MUKE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 10/10/1933 218-31-9662 78 **Director** 1 M 2 F Vietnam "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1103 Vineyard Hill Rd. 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Asian Completed 3 🗌 Widowed 4 🙀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Private Taylor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Khai van Nguyen Hua thi Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Huynh (Son) 1103 Vineyard Hill Rd., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/10/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death .Physinian/ MEMORPHAGE INTEACRANTAZ disease or condition resulting in death) Medical Due to (or as a consequence of) 6 DAYS Examiner HYPERTENSIN Sequentially list conditions, if any, reading to immediate cause. (Discounting Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No __ Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural 28b. Time of Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 18905 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MP SMITH State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene
25 per me,g925,03/15/2012dhb
Reg. No.
Reg. No. Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:590 OWEL 105710 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NIA Johns Hopkins Dria Birthplace (State or Foreign Country) In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Min (Month, Day, Year) Director 1 XM 2 | F -199 Usual Residence of Decedent show and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f shormaric event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 No Oe Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2161 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Deceden Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married þ 2 **X** No Yes Baltimore, Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) sablea traumatic event, Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is medany injury or other ဂ nthon owel arker 19a. Informant's Na /Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) brock 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lansdown, MD -2012 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Ba 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ moss disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (c) as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Puneral Director: After this certificate has been signed by the attending physician and the burial-transi Due to (or as a consequence of) Physician/Medical CERTIFICATION Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? completely filled in by the funeral director, page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury Natural Accident Investigation _ Accide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 26 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

Registrar

DHMH 17 Rev 06-2011

State

filed (Month, Day, Year)

0

32. Registrar's Signature

St baltimore 410 21282

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 14, Day 2012 Year 9:42 P M Pitts Leake Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel 2508 Lyon Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours Min July 15. Months Virginia 231-32-2583 85 1926 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Ty Yes 2 No MD Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21403 2508 Lyon Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. o ģ 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. MD State Dept. of Health College (1-4 or 5+) Elementary/Seconday (0-12) Physician of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumation. ည Mary Bernice Allen Pitts John Leake Pitts, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Keffield St., Roanoke, VA 24019 Helen P. Vaughan - Sister 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Burial 3 Cremation 3 Removal from State 3 - 17 - 12Evergreen Burial Park Roanoke, Virginia 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice ee 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ SAC disease or condition resulting in death) Medical Due to (or as a conse unce of): Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) a to immediate signed by the attending physician and d be detached for use as the burial-transit 00000or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death should be detached 1 La res 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been: . Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

9 Funeral Director. After this certificate has leted filled in by the funeral director, page 2 to autopsv performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21401 mp 2002 Modual State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Amend Items 28a-f, per me, g925, 03/16/2012dhb

Amend Items State of Maryland Department of Health and Mental Hydiene

		1 - State Amend Items 25, Registrar	27 per me,g	3925 0: Cer	##icale 81	Death		10311101				
Physi /Med		Decedent's Name (First, Middle, Last)     Kendra	Nikeisha			rker	2. Date of Dea Month Q2	Day	3. Time of Death 9:45a.			
Exam	iner	4a. Facility Name (If not institution, give street a Future Care Nursi				r Location of Death		4c. County of	of Death			
Funera Directo		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. la	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	v, Year)	Birthplace (State or Foreig Country)     MD			
Maryland f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD NA	,	Town or Loc Balti					10d. Inside City Limits			
death with the Maryland me 23a or 28e-f ehow Charat be notified at	Funeral Director	10e. Street and Number 300 East 22nd Stre	et		10f. Zip Code 212	18		10g. Citizen of W U . S .	hat Country?			
after after		1 Never Married 2 Married 1 ☐	s Decedent Ever in U.S ned Forces? ]Yes �� No es, Give ar or Dates:		Vas Decedent of H Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- American Indian, c, White, etc. Black			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Opportment of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or any injury or other traumatic event, the Mudical Examination.	Completed	15. Decedent's Education (Specify only highest grade comp.  Elementary/Secondary (0-12)  10th grade  Co	eleted) llege (1-4or 5+) na		ent's Usual Occup kind of work done OO NOT use retired ail Sor	nation during most of wor d) ter	rking	16b. Kind of Bu	office			
land 2	To Be Co	17. Father's Name (First, Middle, Last) Timothy Wonson				18. Mother's Nan Brenda	ne (First, Middle, Parker	Maiden Sumame	e)			
Mary and 2 shou alth and M 27 to mar		19a. Informant's Name/Relationship (Type, Pri Brenda King-Mother		19b. Mailine 300 E	Address (Street East 22:	and Number or Ru nd Stre	et, Bal	r,CityorTown,S Ltimore	State, Zip Code) , Md 21218			
imore, Pages 1 a ment of He ant: If Item ury or othe		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	0.0	ace of Dispos metery, crem Mt. 2	sition (Name of attory or other place Zion		Date /2012		City or Town, State			
Balt permit. Departr Imports any inj		21. Signature of Funary Service Licensee	up of	Ma 4.	Name and Address 1700 F/300 Wab	ਜਿੰਾਂ West ash Ave	, Balti	imore,	Md 21215			
Physiciar /Medica	1	23a. Part 1. Enter the disease, or combications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	s that caused the death, se on each line.  Oue to (or as a consequence)	20 Miles	or the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death			
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Oue to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t		Win t	Injury	St. A. N	Pod	A.OO			
68760, rifficate be executed a physicien and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequence Polysub		Abuse	9/1	STORE CATION APP	ROVED BY MEDICA	Para			
P.O. Box 68: that the death certificat ed by the attending phy detached for use as the	Completed by Physician/Medical	in the past 12 months?	es, outcome of pregnar Live birth 2 Fetal ( Pregnant at time of de Unknown	death 3 🗌	Ectopic pregnancy Other (specify)		ERIH W		of delivery			
0 8 8 g	ed by P	Part II. Other significant conditions contribution	ng to death but not resul	liting in the un	derlying cause giv	en in Part I.	23e. Did to		bute to the cause of death?  3 Probably 4 Wunknow			
The la The la ate has page 2	Complete		· · · · · · · · · · · · · · · · · · ·				24a. Was autop perfo 1 □ Yes	rmed? d	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No			
or Attending Physiter death.  Niector: After this in by the funeral dis	funeral director	After this certification director	funeral director	funeral director	2 Accident investigation 3 Suicide 6 X Could not be determined 28e	1   Inpatient 2   E	28b. Time of Injury Unknov	28c. Injur Worl Wn 1 □	ner: 4.⊠Nursing H	Unknows 28f. Location (S City or Tox	dence 6 Other own injury occurred to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	
Hospitel 24 hours a Funeral C	edical C	29a. Certifier (Check only  2 Medical Examiner: O	To the best of my know	wledge, death ion and/or inv	occurred at the tirestigation, in my o	me, date and place opinion, death occu	Baltime a, and due to the curred at the time,	cause(s) and mai	nner as stated. and due to the cause(s)			
within To the comple	Med	29b. Signature and title of certifier	2	MD	29c. Licens	se number	!	· .	(Month, Day, Year)			
		30. Name and address of person who complete	od cause of death (Item	23a) (Type, I	Print) EUTAW	St Sn	to 308	BALTI	more MD 212			
S Regis	tate trar	31. Date filed (Month, Day, Year) 2012	2. Registrar's Signar	wro par	Ked				more MI) 212			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pawelczy 3. Time of Death Month Physician/ 2 gdalenz 9:00PM arch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore City Examiner 4c. County of Death 6603 Hartwait Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mar 3. | 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X 88 Porvte, Poland 214-44-4969 Director Mar Usual Residence of Decedent 10a. State 10c. City, Town or Location at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 3a or 28a-f sh t be notified a Md. Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 23a 21224 6603 Hartwait Street must "natural", or items idical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Year or Dates f Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Kotowski Lipinski Sophia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6853 German Hill Road Baltimore, Md.21222 Andrew Podbielski -Son Maricia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ō Important: If it any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 17,2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Holy Rosary Cem. 22. Name and Address of FacilityKaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee M00933 Dundalk Avenue Baltimore, 1201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Por Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 g the g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I; page 2 s autopsy certificate 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital. 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation Accident 24 hours after deatl 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

5411 Old Frederick Rd Stp. 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cor

Registrar's aignature

an

31. Date filed (Month, Day, Year)

12-02139 Richard Ponton

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.	
Physician/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year	
Medical Examine	Richard Andrew Ponton  March 14, 2012  1720 hrs  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
	Harford Medical Center  Aberdeen, MD  Harford	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) 19. Birthplace (State of Bir	ж
Director	220-82-4969 1X M 2 F 48 Yrs. Months Days Hours Min. 06/23/1963 Foreign Country) MD	
	Usual Residence of Decedent	
w any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City	•
Aaryland 28a-f show 1 at once.	MD Harford Bel Air 1 Yes 2	. X No
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
11215-0036 Id be filed within 72 hours after death with the Maryland dental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. o Be Completed by Funeral Director	207 Hitching Post Drive 21014 USA  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	ak
death with the ritems 23s nust be not Uneral	1. Was becount of rispatile origin ( Specify res of No-  1. Was becount of rispatile origin ( Specify res of No-  1. Was becount of rispatile origin ( Specify res of No-  14. Race - American Indian, Blat  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.	JK,
Rerd F. or	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White	
ours aft atural" samine	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done  16b. Kind of Business/Industry	
5-0036 ed within 72 hour Sygiene. other than "natt the Medical Exan	Elementary/Secondary (0-12)  College (1-4 or 5+)  during most of working life. DO NOT use retired)	
within within Media	12 Disabled N/A 17. Fether's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	
215- be filed on the Hyg ont, the		
212 tould be d Ment is mark tic ever	Dick Daniel Ponton Marie Barbara Boettinger  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Brenda Shannon 207 Hitching Post Dr., Bel Air, MD 21014	Ĭ
Fe, I and I and Healt Fitch	20a, Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	
alti mit. spartm sports jury o	21. Synature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home,	-
	610 W. MacPhail Dr., Bel Air, MD 21014	
Physician /Medical	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Between On	set and
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Complications of salicylate Intoxication  Due to (or as a consequence of):	1
	Sequentially list conditions,  b.	
ner	if any, leading to immediate Due to (or as a consequence of):	
led Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
cuted and transi	d.	
60, rate be executed physician and the burial - transit Medical Ex.	▼ UNPENDED 23a,pt.II,27,28a-f,per me,g926 4-2-12 sm pt.II,per me,g92/ 5-11-12 sm	
Box 68760, death certificate be attending physic of for use as the burnysician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Sox 687 leath certifi e attending for use as t	past 12 months?	ear
BO e deat the at the at by Si	1 Yes 2 No 9 Unknown 9 Unknown	
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending. page 2 should be detached for use as: Completed by Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of de	
w requires t w requires t seen signs should be c	Cardiomegaly; Cocaine Use  1	
aw rec as bee 2 shou	24a. Was am 24b. Were autopsy inkings a autopsy prior to completion of ca	
ital Recidins: The licians: The licians to certificate licetor, page	1 ✓ Yes 2 No 1 ✓ Yes 2 No	No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detainertification: To Be Completed by Fertification: To Secondary	25. Was case referred to medical 26. Place of Death (Check only one)  examiner?  Hospital: 1   Innation   2   I	
n of Vi ding Physi  After this funeral dir	1 Yes 2 No No No Prospital 1 Inpatient 2 ER/Outpatient 3 DOA Norsing Home 5 Residence 6 Other.  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
ading rr Aff	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 X No subject overdosed on Aspi	rin
r Atte r Atte ter des irecto n by ti	Accident Investigation Investigation   fd 3-9-12   fd 06:00 pm   28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street and Number or Rural Route Number or Town, State) 523 Baltimore Ct	er, City
Division o Bopital or Attending 24 hours after death. Funeral Director: Aftered filled in by the funeral Certification:	4 Homicide (Specify) Found: Residence Aberdeen, MD.	•
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the Ho within 24 To the Fu To the Fu completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  March 15, 2012	
	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar	MAR 1 6 2012 James A. Jakes	
DHMH 17 Rev 1/2001	ORIGINAL OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 74**8**M 1910 Medical **Examiner** County of Death BALTIMIC 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 24 Hrs. **Funeral Director** 1 № M 2 🗆 F 09 1942 iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Randallstonr 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 Funeral 8901 Middlebrook USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married "natural", or 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Sweetheart Cup Co. Madrine 12th grade perator Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, WILSON Mitchell 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) andalltown MD 21133 Quarles 8901 Middlebrook Court nema 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Mehamy Church 21/2012 Brodnax, VA Vaugna C. Greene Funeral services Signature of Funeral Service Licensee 22. Name and Address of Facility Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cau e on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 0 DS disease or condition resulting in death) ue to (or as a conse pag Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Pregnant : in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of has autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate 2 No filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? No Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural Accider work? 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Mar Medical 4c. County of Death **Examiner** BALTIMOR -650 Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Months Director 1 🗆 M 2 💢 F 76 MARYLAND 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director ems 23a or 28a-f sh r must be notified a MD CARROLL SYKESVILLE 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iter Examiner 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced WHITE Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha LON BROTHERS SPOOLER Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ f Health and Menta item 27 is marked other traumatic e VIRGINIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VENN (DAUGHTER 21071 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State WINFIELD, MD CARROIL GREM 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J N ZUMBWN IFH & MW Co FLOERSBURG-MO 21754 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician 3 disease or condition resulting in death) Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Hospita 2 **N**o Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed c of death (Item 23) (Type, Print) 10/2 31. Date filed (Mor State **T**6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012^{Year} Month **Physician** 12, March 10:51 PM Catherine Μ. Robinson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard 9126 Grant Avenue Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 💢 F **Director** 579-34-1824 83 04-20-1928 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment instalts in items. 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 No MD Howard Laure1 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9126 Grant Avenue Funeral 20723 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Merchandise/Retail 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) မ James E. Snell Sadie Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Robinson - spouse 9126 Grant Avenue, Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XOXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 03-17-12 Elkridge, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at ac B. Brot MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. El ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) P.0. 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Statement 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No To the Funeral Director: completely filled in by the t 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MD, 10710 Charter Dr., Suite GO20, Columbia, MD 21044

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

Clement B. Knight

31. Date filed (Month, Day, Year)

March 13, 2012

State of Maryland / Department of Health and Mental Hygiene 201 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14 Physician/ March 2012 James Brinton Robinson, Jr 12:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 959 Breakwater Drive Annapolis Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth **Funeral** 1 X M 2 □ F Months Davs Min Cou Maryland (MOBITS,/Pay/Yeg/39 215-34-8131 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 No Annapolis MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or than "natural", or items 23a or the Medical Examiner must be Funeral 21403 USA 959 Breakwater Drive death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) Division Manager Defense event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fish marked of Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. 2 James Robinson, Sr. Margaret Travers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Brinton Robinson, Jr. / Self 959 Breakwater Drive, Annapolis, MD 21403 20a. Method of Disposition
1 □ Burial 2 🌣 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 3/15/2012 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t attending IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Month Day Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has 1 Yes Yes 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? 2 1 Inpatient 2 ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify hours after death. neral Director: After this 28a. Date of injury (Month, Day, Year) funeral Manner of Dath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural Accident 5  $\square$  Pending work?
1 Yes 2 No Investigation the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours a To the Funeral I Medical 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signature and title of 29c, License numbe 29d. Date signed (Month, Day, Year) Name and ad ess of person who completed cause of death (Item 23a) (Type, Print) APRILIMY SUITE 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2012 Physician/ Aaron Lee Russell, Jr. March 14. 10:25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days October 26, 1933 1 X M 2 🗆 F Hours 577-46-3741 78 Washington, D.C. Director Usual Residence of Decedent 28a-f show 10b. Count at 10a State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 ☐ Yes 2X No Rockville Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 14014 Parkvale Road United States death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 3 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Offset Printer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Grace Lee Bril1 Aaron Lee Russell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14014 Parkvale Road, Rockville, Maryland 20853 Donna Russell /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of March 19. 20c. Location - City or Town. State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2012 Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 Missel 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1/ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Pulmonary Fibrosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Coronary Artery Disease, Pnemonia, Rheumatic Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Lung Disease 24a Was an aw has e 2 autopsy performed Yes 2 X bage ; Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) Hospice 1 ☐ Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural injury 5 Pending Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi 2 Deducal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year, R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 CRNP Debrah Miller, State Registrar

W

12-02050 Barbara A Robinson

## Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of Death	, R	eg. No.	
Physician	7	Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year	3. Time of Death 1515 hrs
Medical Examine		Barbara Ann Robinson	March 11	, 2012 4c. County of Dea	
)	ď	ta. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death 1520 Mountmor Court  Baltimore		/A	
Funeral	١,	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	. 8. Date of Bi	rth (MM/DD/YYYY) 9. B	irthplace (State or
Director	L	215-76-3901 1 M 2XF 54 Yrs. Months Days Hours Min	3/1957 Fore	ountry) MD	
à	-	Usual Residence of Decedent   10c. City, Town or Location   10c.			10d. Inside City Limits
<b>*</b>	_	MD N/A Baltimore			1 XYes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	1	l0g. Citizen of What Co	untry?
with the Maryland ns 23a or 28a-f sho be notified at once		1521 Mountmore Ct. 21217		U.S.A.	
h with	9 2	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,
or ite	runera	1 Yes 2 X No		Specify: B1	ack
hours after death with the Maryland unstural", or items 23a or 28a-f she Examiner must be notified at once	⋛	15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of V	work done	16b. Kind of Business	
5-0036 style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of the style of th	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use reti	red)		
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dental larked cvent,	200	Marshall Cole Catheri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			te, Zip Code)
of shad shad shad shad shad shad shad shad	2	Darlene Cole-Hope(Aunt) 2345 Lauretta Ave.			
e, M I and 2 Health Fitem 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
<b>5</b> % 2 ≥ ₹	1	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: On-site Crematory 03/	/14/12	Baltimor	e, MD
Baltimore, permit. Pages I au Department of He Important: If ite Important: If ite Injury or other tr	ŀ	21. Signature of Funeral Service Licensee,	Jr. F	uneral Ho	me PA
E E E	1	Dietuch N. William 2140 N. Fulton I			, MD21217
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory an	rest, shock, or neart	Between Onset and Death
xaminer	1	Immediate Cause (Final disease or condition resulting in death)  a. Diabetes Mellitus  Due to (or as a consequence of):			
	1	Sequentially list conditions, b			
		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
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Box 687  e death certific  the attending p  ed for use as th	Physician/	1 Yes 2 ✓ No 9 Unknown 9 Unknown			
bat the etache	<u>8</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute	o the cause of death?
S, P uires t uires t	8		24a. Was		autopsy findings available
ord aw req as bee	Completed		auto		completion of cause of
Rec The Licate h	튅		1 ✔ Yes	2 No 1 🗸	Yes 2 No
ician: ician: s certif	8	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Wurst		Residence 6 V Ott	er: Scene
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the after death.  **All Divector** After this certificate has been signed by led in by the funeral director, page 2 should be detactiven by the funeral director.	의	1 Yes 2 No I I Inpatient 2 Ervoupatient 3 505 7 Notes  27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work?		how injury occurred	
on Conding ath.	틹	Natural 5 Pending 1 Yes 2 No			
ViSic or Atte her der hirecto in by t	<u>ड</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town,		Rural Route Number, City
Dital cours at ceral Diffilled	Certification:	4 Homicide determined (Specify)		<del>_</del>	
	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cau at the time, date	use(s) and manner as si e and place, and due to	ated. the cause(s)
To with	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)
		O.C.M.E.		March 12, 2012	2
	ŀ	30. Name and address of person who completed cause of death (Item 23a)		4000	
		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltin	more, MD 2	1223	
Sta Registr	•	31. Date filed (Month, Day, Year)  MAR 1 6 2012  32. Registrar's Signature		OCM	The Land

State

Registrar

31. Date filed (Month, Day, Year)

1 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item25 State of Maryland / Department of Health and Mental Hygiene per me,g925,03/15/2012dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAR 2 CI2 3: 50 PM SITERHAN MARGARET Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD GENERAL HOSPITAL COLUMBIA HOWARD COUNTY 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Days Hours Min (Month, Day, Year) **Director** 1 🗆 M 2 🕱 F 044-16-1218 02/11/1923 89 CT 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Columbia MD Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 6336 Cedar Lane 21044 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. 0. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify "natural", Specify: 3 ₩ Widowed 4 □ Divorced White Completed Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Machine Manufacturing Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Stickles Johanna Krause 1 and 2 should k of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8646 Bali Road Ellicott City, MD Edward J. Sherman, Jr. - Son or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or of ☐ Burial 2 ☐ Cremation 3 😾 Removal from State 03/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Kings Highway Cem. Milford, CT 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signature of Funeral Service Licensee Collin-W 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ GASTROINTESTINAL LIE MORIZHAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner wie Hlelo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death should be detached the Unknown P.O. þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 1 ☐ Yes 2 KNo certificate Yes 2 KNo Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: X Yes 1 X Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? s after death. I Director: After the Certificate: 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of g 29c. License number 29d. Date signed (Month. Day. Year) 050404 PHYSICUM 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AI Kesh Patel, InD.

Registrar

DHMH 17 Rev 06-2011

State

SUITE 111

COUMBIA

21044

PKWY

PATRIXENT

10632 LITTLE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ WILLIAM WASHINGTON **SELLERS** JR. MARCH 6 9:10  $\mathbf{p}_{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5015 E. BIDDLE STREET BALTIMORE CITY N/A Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Davs Hours 216-42-9228 **Director** 1**X** M 2 □ F 65 Yrs. 9-1-1946 ALABAMA Usual Residence of Decedent show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director or 28a-f MD N/A BALTIMORE CITY 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5015 E. BIDDLE STREET 21205 U.S.A. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 - Widowed 4 - Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BRICKLAYER UNION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file and Mental F is marked ot ပ WILLIAM WASHINGTON SELLERS, SR. CHARLOTTE WATERS Department of Health and Important: If item 27 is n any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $5\,0\,1\,5\,$  E. BIDDLE STREET BALTIMORE, MD REBECCA A. SELLERS/WIFE 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🎦 Cremation 3 ☐ Removal from State METRO CREMATORY 3-12-2012 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ LUNG Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (chas a consequence of) executed the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? detached for Day Month Year 1 Yes 2 No 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an certificate has autopsy performed? To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 1 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After completely filled in by the funer Natural 5 Pending 1 Yes 2 No __ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LEDAKIS address of person who completed cause of death (Item 23a) (Type, Print) BAOTIMONE

DHMH 17 Rev 06-2011

State

Registrar

MAR 1 6 2012

68760

Box (

P.O.

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4a, perPHYS#19b, perFH, G925, 3/30/2012, ws

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day / / Month 3 Physician/ 5:29 AM Raymond Silvestn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD ABINGDON Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 216-32-5656 **Director** 1**X** M 2 □ F 76 2-20-1936 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location rector BALTIMORE DUNDALK 1 Yes 2 X No MD Ö 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 6928 CONLEY STREET U.S.A. 21224 items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates 1958-60 1 Yes 2X No Specify: Completed 3 Widowed 4 XDivorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

n 27 is marked other than "r
er traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) SALESMAN INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta. Important: If item 27 is marked to any injury or other traumotic once. 2 SILVESTRI MARGHERITA PANICCIA NICHOLAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 RACCOON COURT ABINGDON, MD 21009 MICHELE SILVESTRI/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3-15-12 BALTIMORE, MD HOLY REDEEMER CEM Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 ROSEDALE, 1211 CHESACO AVE MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i ian Heall Congestive disease or condition Medical resulting in death) **Examiner** Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death be detached the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has 2 🗌 No After this certificate Yes 2 XNo 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence XXOther (Specify) DAUHIER'S 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of HUSE Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident work?
1 Yes 2 No within 24 hours after death. To the Funeral Director: A the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical 1 🛎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29h. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 36895  $\theta_j$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225.6/eene 2120 13a Honore MAR 1 6 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 2.45 A M Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NULSing Home ltim Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Director 1 - M 2 X 15-1919 nce of Decedent 28a-f shov 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 X Yes 2 No timore ō 10f. Zip Code 10g. Citizen of What Country? 23a 00 USA or items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗡 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Black 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Secondary (0-12) Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ried1-Daug Baltimore Department of Health Important: If item 27 5 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State Kandallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 10/2012 Signature of Funeral Service Licensee 22. Name and Address of Facility March FH-East 1101 E North Ave 1timore, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) ry known Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 M N 2 🗆 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 29d. Date signed (Month, Day, Year) 00000000 3/16/2012 2 nd address of person who completed cause of death (Item 23a) (Type, Print) Belt 762 4052 31. Date filed 32. Registrar's Signature

State

Registrar

MAR 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ G. Sclafani 8:30 P. 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4622 Clermont Road Pylesville Harford 8. Date of Birth (Month, Day, Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Days Hours 124-10-5355 Director 1 □ M 2 😿 F 91 May 26, 1920 New York 28a-f show 10d. Inside City Limits aţ 10b. County 10c. City. Town or Location Director must be notified 1 Yes 2xXNo Maryland Harford Pylesville or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21132 United States 4622 Clermont Road items death \ Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc than "natural", or 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2**XX**Nc Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White 3X Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Maria Amodeo traumatic Serafino Grande permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4622 Clermont Road Pylesville, Maryland 21132 injury or other Mary Wagner / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mar. 19. 1 Burial 2 Cremation 3 Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Prospect Hill Cemetery Hampden, MA 2012 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signature of Ineral Service Licenses any 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fai Wire Physician/ months e disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine as a consequence of requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 physics the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, in 24 hours after death.

He Funeral Director: After the reletely filled in by the funera 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifie 10 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LO, STEC, VARRETTSMIE!

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 14, 2012 6:00 A SOLOMON ELIZABETH Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) Nov 05, 1918 93 Pennsylvania Director 215-30-2724 1 - M 2 -Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director 1 Yes 2 - No MD Harford Forest Hill 0 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral USA 21050 1611 Honeysukle Dr. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Examiner Black White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 HWidowed 4 Divorced White Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 8 Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Champ Unk Unk 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kamiel B. Solomon /Son 1611 Honeysukle Dr. Forest Hill, MD 21050 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State Mar Beltsville, Maryland 4 Donation 5 Other (Specify) 2012 Chesapeake Crematory 21. Sign ure of Funeral Service Licenses 22. Nacremation Fand Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_{sician/} CANDIO disease or condition resulting in death) Medical Due to (or as a consequence of Examiner yean. nan succitedly flet exposition Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed þ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) ww 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD 21014 DAVID DUNN BEL AIR, MD.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

			for State Registrar	State of M	aryland			it of Heal e of Deat		Mental Hy	0	201	2 (	18221
	Dhusiais	/	Decedent's Name (First, Middle)	, Last)			.,,,,,,	3 07 Boat		2. Date of D				me of Death
	Physicia Medio	cal	Raymond	F.	S	anto1			_	March	1	4 2012	4:	10 A M
	Examir	ier	4a. Facility Name (if not institution, 2828 Gracefiel				4b. City,	Town, or Locat Silver			4	c. County of Dea	th gome1	C37
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. las	t birthday)	If Under	1 Year If Ur	nder 24 Hrs.	8. Date of Bi	rth	9. Bir	tholace (S:	tate or Foreign
	Director		139-12-5607 Usual Residence of Decedent	1 XM 2 □ F	88	Yrs.	Months	Days Hou	urs Min.	Sept.	22 <b>,</b>	1923 N	lew Je	rsey
	and show	Ď	10a. State 10b. County		10c. City,	Town or Loc	cation .						10d. Insi	de City Limits
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	ith the 3a or t be n	ralD	10e. Street and Number				10f. Zip				10g. C	Citizen of What Co		
	ems 2	Funeral	2828 Gracefiel	12. Was Decedent B	Ever in U.S.	13. V	Vas Deced	20904 lent of Hispanio	Origin? (St	pecify Yes or No	-	United  14. Race - Ame		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2 ☐ Marr 3 🏋 Widowed 4 ☐ Divorced	No 1 <b>9</b> / <b>9</b>	If	f Yes, spec	ify Cuban, Me 2 <b>X</b> No <i>Sp</i> e	kican, Puert	o Rican, etc.)		Black, Whit			
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pu	filed wal Hyg	Be o	17. Father's Name (First, Middle, L	,				18. N		me (First, Middle				<u> </u>
yla	uld be Ment narker	유	Frank		ntol1	,,			Lucil				iati	
, Maryland	nd 2 sho ealth and m 27 is n		19a. Informant's Name/Relationsh Raymond F. San							ral Route Numb		ing, MD	p Code) 209	004
Baltimore,	gelantofH : if itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3  Removal from State	cen	ce of Dispos netery, crem	natory or o	ther place)	00/1	Date	20c. l	Location - City or		
Ħ	nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (S	-						5/2012		Beltsvi	IIe,	MD
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			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that caused nly one cause on each line	the death.	Do not ente	er the mode	e of dying, such	n as cardiac	or respiratory a	rrest,		Approx	ximate Il Between
	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)		EMIC		OMYOP	ATHY					Onset	and Death
	Examiner			Due to (or as a	a consequer	ice oi):						V		
	o d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequer	nce of):								
	xecute n and al-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	a consequer	nce of):								
260	cate be executed physician and s the burial-transit	edical		d										
6876			IF FEMALE:	00. 1/	-5				-					
ŏ	attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal c	death 3	Ectopic p					23d. Date of de Month	livery Day	Year
P.O. Box	t the de by the a tached	hysi	9 Unknown	9 □ Unknown										
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B	ian: T		25. Was case referred to medical examiner?					26. Place of	Death (Chec		2X_X\	o 1 L Yes	3 2 □ No	,
₹	Physic this ce al dire	유	1 ☐ Yes 2XXNo  27. Manner of Death		ent 2 EF				Nursing H			6 ☐ Other (Spec	ify)	
Division of Vital Records,	<b>lling</b> r. After funer	Certificate:	1XXNatural 5 ☐ Pending 2 ☐ AccidentInvestig	ation		8b. Time of injury	M 28	3c. Injury at work? 1 ☐ Yes	2 🗆 No	28d. Describe	how inju	ry occurred		
Divis	tal or At irs after c al Direct led in by	2 Accident 3 Suicide 4 Homicide Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Rot City or Town, State)  29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,										ral Route N	lumber,	
	ne Hospi in 24 hou ne Funer pleted fil											cause(s) and	d manner stated.	
	Vith Vom		29b. Signature and title of certifier	10				License numb	er		29d. Da	ate signed (Month	, Day, Yea	
	NIM	-	30. Name and address of person w	the completed assess of the	eath (Itom 0)	30) (Time D	rint)	D37142			ľ	MARCH 14	, 201	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 03 HANAN AHMAD SABRA 09 10:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6322 BUTTERCUP LANE UPPER MARLBORO PRINCE GEORGES Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Days Hours Min Yrs **Director** 614-80-0278 0 - 24LEBANON Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 6322 BUTTERCUP LANE 20772 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify "natural", 3 Widowed 4 Divorced Specify: WHITE Completed event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSE MOTHER HOME MAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be filed of Health and Mental H if item 27 is marked ot ir other traumatic even မ Ahmad Sabra Mariam Sabra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shouke Ayoub (Son) 5532 Lacross Ct., Fairfax, VA 22032 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ₹ Department of Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Page 1 3/10/2012 AMAA Cemetery Stafford, VA 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License Metropolitan Funeral Service Vine St., Alexandria, m01284 5517 VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. attending physician and for use as the burial-transit that initiated events Due o or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death ate has been signed by the page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No __ Yes 25. Was case referred to medical **Director:** After this certific I in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗀 Nursing Home 5 Residence 6 Cher (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 0101245174 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLINSPRINGSRD ARLINGTON, VA YASIN , MD 6115 SABIHA 31 Date filed (Month Day 32. Registrar's Signature State MAR 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 15, 2012 12:10P LEVELLE **GENTRY** SMITH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Towson Arden Courts If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 03/05/1933 Maryland Director 212-32-0824 1 □ M 2**XX** F 79 Usual Residence of Dece show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes XX No Maryland Baltimore Towson ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 8101 Bellona Avenue 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 XXNo
If Yes, Give Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify Specify: White Completed 3XX Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Eleanor O'Conor William Daniel Gentry Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel C Smith 3730 Orchard View Drive, Glenville, Pennsylvania 17329 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2XX Cremation 3 ☐ Removal from State GreenMount Crematory 03/16/2012 Baltimore, Maryland Donation 5 D Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the dise shock, or heart failure ncations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-tra resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Year Pregnant at time of death Day signed by the at d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform After this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Speci 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after death Funeral Director: the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 📂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

within 2 To the 8

only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ST

TOWSON

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ March 12, Dolores Clementine Szymanik 7:10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 215-12-7962 1 🗆 M 2 🔀 F 89 June 24, 1922 Maryland Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Baltimore Parkville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be 8820 Walther Blvd. 21234 TISA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or itel Black, White, etc o, þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frederick William Yahde Rose L. Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Hood Court, Churchville, Maryland 21028 Darlene J. Seippel / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Ren oval fro Bel Air Memorial Gdn: 3/17/2012 Bel Air, Maryland 4 Digionation 5 Nother (Specification) Type Tombanent McComas Funeral Home, P.A. 22. Name and Address of Facility 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si i n END STAGE CARDIAC DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the hurial-tree use as the burial-trar Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Hospital or Attending Physician: The law requires that the death Day Pregnant at time of death Month Year been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe After this certificate 2 🗆 No Yes 2X N 1 Yes Division of Vital filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 🕱 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No after death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ha To the Fune completely (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) ssof person who completed cause of death (Item 23a) (Type, Print) W JACKIE JONES. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State Registrar

DOLORES SZYMANIK

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20 12 March 13, Physician/ 6:10 PM Huishu Sun Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) Country) Days 579-23-5276 Director 1 □ M 2 🗓 F February 1, 1942 70 China Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10b. County the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Derwood Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral 7726 Havenside Terrace 20855 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Educator Hospita1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည He-Zhen Wei Chang-Yan Sun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Concepcion/Daughter 18911 Festival Drive, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place)
Montgomery
Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) March 18,2012 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Leukemia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-tran Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year signed by the at Id be detached f 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy this certificate has 2 No 1 Yes Yes Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending 1 X Natural iniury Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20855

State Registrar

32. Registrar' Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3:24 AM Physician/ 20\est Lar Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 50 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) Director 071-46-8364 1 □ M 2 💢 F Yrs 12-29-1953 Ohio 58 Usual Residence of Deceden or 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 🏹 No Anne Arundel Maryland Linthicum 10e. Street and Number 10f. Zip Code ь 10g. Citizen of What Country? items 23a or ner must be n Funeral 1171 Winterson Road, Suite 401 21090 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4X Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetic. Elementary/Secondary (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Stewart Helen Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 Suite 401 Linthicum, Maryland Charles Stewart 1171 Winterson Road, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spring Grove Cemetery Cincinnati 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland la cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest a cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final · avorcular Ph sician/ otherosules atic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consectionne off Examir Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death ate has been signed by the a page 2 should be detached Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an • Hospital or Attending Physician: The law r 24 hours after death.
• Funeral Director: After this certificate has b. autopsy performed? Yes 2 No death? 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ၉ ER/Outpatient 3 DOA 1 Inpatient 2x 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accider 5 Pending iniury Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) gb. Signature and title of certife 29d. Date signed (Month, Day, Year) 306 e and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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Physicia Medical Examin	ın/	Registrar  1. Decedent's Name (First, Middl Gary Wayne	e,Last) Shaffer	_					2. Date of Dea Month March 13	ath Day	Year	3.	Time of Death
reulcai Exami		4a. Facility Name (if not institution 3868 Sykesville Road	n, give street and nu	umber)	4	b. City, Town, Sykesville		of Death	Water 10	4c.	County of I	Death	
Funeral Director		5. Social Security Number 217-50-6149	6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Y		der 24Hrs.	8. Date of B	•	16	oreign	lace (State or try) PA
ind show any nee.	F	Usual Residence of Decedent 10a. State 10b. County MD Carr		10c. City,	Town or Location							1	0d. Inside City Limits
the Maryla	Dire	10e. Street and Number 3868 Sykesville	e Road			10f. Zip Code 21784						t Country	/? 
15-0036 filed within 72 hours after death with the Maryland I Hygiene. ed other than "ustural", or items 23s or 28s-f show t, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div		2 No	lf Y€	Decedent of les, specify Cub	an, Mexica	n, Puerto I		s	White, Specify: W	_{etc.} hite	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed b	15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Decedent during mo	st of working I	ife. DO NO	T use retir	ed)	Che Cor		ake	n Services
2 2 E 2 5	Be	17. Father's Name (First, Middle Hoarce L. Shaf	fer		1	Address (St	Shi	rley	(First, Middle, B. Arm	acost	t	Cinta 7	(in Codo)
MD 2' and 2 should saith and Mi em 27 is ma	٤	19a. Informant's Name/Relations Mary Beth Shaf 20a. Method of Disposition			3868 Place of Disposi	Sykesv	ille 1	Road	Sykes Date	ville	ocation - C	217	'84 
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Mc Important: If item 27 is ma injury or other traumatic er		1 Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Emeryl Services	pecify:		illtop S				6/2012				ryland ome, Inc.
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/Necical Examiner	9 43	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Contact G	unshot Wour		rso						-	Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	a consequence o									
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68760, certificate be anding physicine as the buri	\$	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?  1 Yes 2 No 9 Un	he 1 Live	nant at time of de	2 Fel	al death ner (Specify)	3 Ecto	oic pregna	ncy		. Date of d Month	lelivery Day	y Year
P.O. B res that the designed by the	è	Part II. Other significant condi	tions contributing	to death but not i	resulting in the u	nderlying caus	e given in I	Part I.			No 3		e cause of death?
cords aw requinas been 2 should	Completed								peri 1 ✔ Yes	opsy form <u>ed</u> ?	pri de		psy findings available inpletion of cause of
Vital Reciysician: The l	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA		Nursin	g Home 5		nce 6 🗸		Scene
ion of tending Pheath. tor: After the funeral			iding Mar 13	e of Injury th Day Year) , 2012	28b. Time of Ir 1054 hrs	1	njury at Wo	<b>∕</b> No	28d. Describe Subject sh	ot self			
Divisior spital or Attend tours after death neral Director: filled in by the	Certification	3 Suicide 6 Cou	ermined (Specify	) Single Far					or Town, 3868 Sykes	State) ville Roa	d, Sykes	ville, MI	
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Ex	Physicien: To the be aminer:On the basis and manner	of examination	dge, death occur and/or investigat	ion, in my opir	ion, death	occurred a	due to the ca	e and pla	ce, and du	e to the	cause(s)
	W	29b. Signature and title of certif	ier Kithall, M	D			ense numb C.M.E.	er 			ch 14, 2		h, Day, Year)
141		30. Name and address of perso Pamela E. Southall, I		use of death (Iter t Medical Exa	_{m 23a)} aminer 900	) W. Baltim	ore Stre	et, Balti	more, MD	21223			
S Regis	tate	A land of the second second		Registrar's Signa	ture	1							

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 08232

		Registrar	e of Death	Reg. No	).	
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) John Richard Sellman , Jr.		2. Date of Death Month Day February 28, 2	Year 2012	3. Time of Death 1731 hrs
		4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of Death Bel Air		c. County of Death Harford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 213-74-6311 1 M 2 F 55	y) If Under 1 Year If Under 24Hrs Months Days Hours Min	<b>-</b>	9. Birti Foreigi 1956 Ma	า
Aaryland 28a-f show any 1 at once,	٥٢	Usual Residence of Decedent  10a. State				10d. Inside City Limits  1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street end Number 3523 Orchard Avenue	10f. Zip Code 21244 – 2960	. 10g. Ci	tizen of What Coun	try?
r death wi or items	Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 N Divorced If Yes, Give Year	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     Yes 2 No specify:		14. Race - Americ White, etc.	wen Indian, Black, White
36 nin 72 hours at than "natural dical Examin	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	eadent's Usual Occupation (Give kind of ving most of working life. DO NOT use reting the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contr	red)	Kind of Business/Ir	
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MD 2121 nd 2 should be in the and Mental n 27 is market numatic event	To Be	John Richard Sellman, Sr.  19a. Informant's Name/Relationship (Type, Print)  John R. Sellman, Sr/Father 135	lailing Address (Street end Number or I	B. Meye Rural Route Number, ( e Baltim	City or Town, State,	Zip Code) . 21224
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of D crematory  Bayvie	isposition (Name of cemetery, or other place) W Crematory 3,	Chate C n 20c.	Location-City or 1	own, State e,Marylan
Physician		21. Signature of Fureral S rvice icensee M00933  23a. Part I. Enter the visease, or complications that caused the death. Do not en	22. Name and Address of Facility Kac  1201 Dundalk Av  Iter the mode of dving, such as cardiac of	ZOTOWSKÍ enue Bal r respiratory arrest, sh	funera.	Home, PA  Md. 21222  Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Morphine and An Immediate Cause (Final disease or condition resulting in death)  a. Cardiomegaly  Due to (or as a consequence of):	phetamine Intoxica	tion compl	licating	Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (C.				
cuted and transit	Exa	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.				
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	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Tegnant at time of death 5 Unknown	Fetal death 3 Ectopic pregna Other (Specify)	incy	3d. Date of delivery Month Da	ay Year
i, P.O. Baires that the designed by the	۵	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the	ne cause of death?
aw requires been 2 should	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of 2 No
Vital Rec hysician: The I this certificate I	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 FR/Outpa	26.Place of Death (Check attent 3 DOA Other Nursin		ence 6 Other:	<del></del>
ion of vending Ph. eath. or: After the funeral		27. Manner of Death 1 Natural 5 Panding (Month, Day,Year) 28b. Time (Month, Day,Year)	28c. Injury at Work?  1 Yes 2 X No	28d Describe how in subjetc in		edication
Division  To the Hospital or Attendid within 24 hours after death. To the Funeral Director: A completely filled in by the fi	E I	3 Suicide 6 Could not be determined (Specify) Found in	street, factory, office building, etc.	or Town, State)	and Number or Rura aul Marti dgewood,	
o the Ho ithin 24 } o the Fui mpletely	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
F. 2 E 8	Me	29b. Signature and title of certifier  Panatic Southall, MI)	29c. License number O.C.M.E.		Date signed (Monto	
		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner	900 W. Baltimore Street, Balti	more, MD 21223		-
St Regist		31. Date filed (Month, Day, Year)  MAR 1 6 2012	Mal			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LURNER Month Physician/ CORNELIUS 2012 6:38AM HENRY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK 100 MADISON ST. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Stor. 2 Hours 571-34-7813 **Director** 1 📝 M 2 🗆 F VIRGINIA 89 28 1922 or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified FREDGRICK MO. FREDERICK Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? items 23a Funeral MADISON 21701 U.S. A 100 12. Was Decedent Ever in U.S. Armed Forces?
1. ✓ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) FREDERICK COUNTY and Mental Hygiene. is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+)
4 YEALS GOUCATION-TEACHER SCHOOL BOARD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CORNELIUS H. TURNER LEOLA C. TURNER KING other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau MASISON ST. FREDERICK MARGARET N. TURNER (WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, RESTHAVEN MEM. GAR, MAR 20, 2012 FREDERICK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLING FINGUR IDME Signature of Funeral Service Licensee Rollis suy 2. HOWEST SOUTH ST FREDERICK, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Demento Physician/ disease or condition resulting in death) Medical **Examiner** Diabeles Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the buria Physician/Medical P.O. Box 68760 as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? has 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of nours after death.

neral Director: After the filled in by the funera Certificate: 28c. Injury at work? Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MD. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Montclaire Ave Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Name (First Middle, Last) 2. Date of Death Physician/ Medical **Examiner** If Under 1 Year If Under 24 birs 8. Date of Birth **Funeral** Days Months (Month, Day, Year) 02/28/1924 Country **Director** 026-16-6524 1 XM 2 □ F 88 Massachusetts show 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 XNo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 3700 International Drive #233 United States ural", or items ? LExaminer mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give WW Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give WW II 1 ☐ Yes 2 🔀 No Specify: "natural" 3

Widowed 4 □ Divorced White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Federal Government and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Health Science Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert Eddy Tolman Katherine Rebecca Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David H. Tolman 10602 Hayes Ave. Silver Spring, Maryland 20902 (son) 20a. Method of Dispo 20b. Place of Disposition (Name of MARDate 14, 20c. Location - City or Town, State Department of P Page 1 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 2012 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the attending physician and resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an this certificate has autopsy prior to completion of cause of death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital No ပ 1 Yes Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: Manner of Death Date of injury 28b Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 2 Accident injury (Month, Day, Year) work? 5 Pending 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cybrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature an of person who completed caus 3a) (Type, Print

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 14, Physician/ Tudor 2012 5:45A. Mildred Rose Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hart Heritage Estate Street Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 183-18-7390 **Director** 1 □ M 2 🗓 F 87 Mar.24,1924 Maryland show notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 28a-f 1 Yes 2 No Baltimore City Md. 10f. Zip Code 10e. Street and Number ms 23a or must be r ō 10g. Citizen of What Country? Funeral 21224 East Avenue 417 South U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black White etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Beautician Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose John Marie Ramiszewska 19a. Informant's Name/Relationship (Type, Print)
Paulette Wirsching/Daughter 2731 Conowingo Road Bel Air, Md. 21015-1005 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Oak Lawn Cemetery 19,2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facil ACZOROWS 1 Funeral Home, P.A. Signature of Funeral Service Licensee M00933 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phui i n 401.2 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter chaerlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an after death. I Director: After this certificate has t المالية بالمالية المالية الما perform 1 ☐ Yes ŽXXNo 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: ASSISTED LIVING 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 XNatural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide within 24 hours To the Funeral I Medical 崔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 06-2011

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 1 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

D 39889

Alfred D. Sparks, M.D. 615 W. MacPhail Road Suite 106, Bel Air, Md.

21014

29d. Date signed (Month, Day, Year,

March 14, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH FRANCES A. THOMAS 2012 10:45 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE - RUXTON TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/29/1924 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Hours Min MARYLAND **Director** <u> 218-18-4283</u> 28a-f shov 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD N/A 1X Yes 2 No BALTIMORE CITY 10e. Street and Number ö 10g. Citizen of What Country? must be r Funeral 6701 PARK HEIGHTS AVENUE 21215 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced Specify: WHITE Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) STORE OWNER BASKIN ROBBINS 10TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be JOHN VANANZO ROSE DIGENNARO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, 6701 PARK HEIGHTS AVENUE APT. 1E DEBORAH THOMAS/DAUGHTER Baltimore, Department of Heall Important: If item 2 any injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 🚻 Burial 2 🗆 Cremation 3 🗆 Removal from State GARDENS OF FAITH CEM. 3/17/2012 PARKVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Ly ensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, MO1139 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No 2 No Be ( funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) (125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lewis Anne

State

Registrar

31. Date filed (Month, Day

MAR 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 3:20 PM Wilbur Weber Robert MAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL AGNES IMORE 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2 □ F Months Davs Hours March 18 1935 Mary Tand 76 Director 218-30-6735 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Heathville VΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 22473 1612 Mila Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Company Security 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Roberta Elizabeth Herin Wilbur Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1916 Woodside Avenue Halethorpe Maryland 21227 Gerald Weber- Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mar. 15 2012 GLen Burnie Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signature A Funeral Service I 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ETASTATIC Physician/ WO MONTHS disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions Due to for as a consequence of: cause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No Month Dav Yea Pregnant at time of death 5 Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 X No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 💢 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗆 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V WILKENS AUF #307 QUAINDO MO BENEZER 31. Date filed (Month, Day, Year) State MAR 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Reginald Charles Westlake March 10:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 546 Russell Ave. Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Min (Month, Day, Year) Months Hours Director 220-60-3323 1 XM 2 🗆 F 95 Aug.5, 1916 England Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City. Town or Location the Maryland notified at 10d. Inside City Limits Director 1x Yes 2 □ No MD Montgomery Gaithersburg 10e. Street and Number ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 546 Russell Ave. 20877 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Financial Director Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Richard Westlake Delsie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Westlake / son 15 Ascot Close Eastbourne, EastSussex BN20 7HL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 3/16/12 Woodbine, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784

Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Adult Failure to Thrive Medical resulting in death) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical certificate be P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Tes 2 No 3 Probably 4 Tunknown Hypertension, Hyperlipidemia, Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No Yes 2 X N 1 Yes **Division of Vital** 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) Hospital: 1 Yes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) It R frat sevent March 14, 2012 04115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 107 Robert Birschbach. 201 Russell Avenue Gaithersburg, MD 20877 M.D. te filed (Month, Day, Year)
MAR 1 6 2012 31. Date filed (Month, 32. Registra 's Signa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 10:15 am aola Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MON! Ore Age (In yrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours **Director** 1 🗆 M 2 🗹 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. hside City Limits **Funeral Director** must be notified 28a-f 1 Yes 2 No MD ö 10g. Citizen of What Country? 23a items Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced "natural", al Hygiene. d other than "natura event, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Secondary (0-12) Elementary College (1-4 or 5+) omema Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked of r other traumatic ever ည Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rulal Route Number, City or Town, State, Zip Code) of Health Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or oth Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) brook Virginia Funeral Service Licensee 21. Signatu Hame and Address of Facility 2022 Home, Funeral SS MD 23a, Part / Enter he disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ MYDC disease or condition Medical resulting in death) **Examiner** Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 DNo

9 Unknown Month Pregnant at time of death Unknown been signed by the a should be detached t P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy performed' 1 Yes 2 🗌 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 은 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 10020111 15-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION

State Registrar 21. Date filed (Month, Day, Year)
MAR 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wayne Wilt 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico the Hospice at Salisburu If Under Sex If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Months Maryland Hours Min. (M874/27/1953 091-46-7670 58 Director Usual Residence of Deceder 28a-f show 10a. State with the Maryland notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be r Funeral 438 Ocean Parkway #53 21811 USA 12. Was Decedent Ever in U.S. Was Deceud... Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpet Cleaner Service Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 August Messenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harley Wilt / Daughter 11429 Manklin Creek Rd., #E7, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial Cremation 3 Removal from State Chesapeake Crematory 4 Donation 5 Other (Specify) 3/16/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DIOM YOFATIX Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ☐ Pregnant a ☐ Unknown signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy After this certificate has 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital ၉ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 733 130 p 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mar. 13, Day 2012 Pear Audrey V. Wilson 5:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1823 Twin Oak Road Jarrettsville Harford 8. Date of Birth Aug. 9, 1934 Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** MDountry) Days Hours 1 🗆 M 2 🖵 F Months 213-30-0897 77 Director Usual Residence of Decedent ns 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Yes 2 ☐ No Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1823 Twin Oak Road 21084 USA ed other than "natural", or items event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 1 and 2 should be filed within 7 of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Ms. Elementary/Seconday (0-12) College (1-4 or 5+) 10th Rosewood Center Nursing Assi stant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Melvin Wilson Mildred Summerville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardena Walker (daughter) 1823 Twin Oak Rd, Jarrettsville, MD 21084 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parkwood Cem. 1 Sp Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mar.20,2012 21. Signature of Euneral Service Licensee Cally Add B. Scruggs Funeral Home 1412 E Preston St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - hysician/ DISCASE CORONARY ARTERY Medical resulting in death) Due to (or as a consequence of): **Examiner** PERTENSION Sequentially list conditions, Examine Out to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury DIABETES ear. the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last 10 years Physician/Medical ZOlesTEROLEMIA Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer page 2 s this certificate has funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 29b. Signature and little of certified D0051779

State Registrar

CULION 31. Date filed (Month, Day, Year)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

WILLIAM J.

MD

4940 EASTERN AVE , BALT. , MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 March 13 Physician/ 5:10 pm Marcella Louise Wittich Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Parkville Oak Crest If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, Feb 26, 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🗀 Months Director 1918 216-05-0025 Maryland Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location octant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 72 hours after death with the Maryland Director 1 Yes 2 X No MD Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21111 U.S.A. 1410 Magers Landing Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates. Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mary Woodward permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1410 Magers Landing Rd., Monkton, MD Richard R. Wittich-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 3/15/12 Towson, MD 21. Signature of Funeral Serve Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 1050 York Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a some squence of, n any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo 1 ☐ Yes ∠ 9 ☐ Unknowy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hiknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performe 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be **Division of Vital** 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 3-14-2012 RO67343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud PARKVIlle UD WALTHEA State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Rebecca Wachter 4:03A March 1 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 233-36-4460 Hours **Director** 1 M 2 X 88 12-20-1923 WV 28a-f show 10a. State the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified PA York New Freedom 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code ems 23a or r must be r 10g. Citizen of What Country? Funeral 50 Stone Ridge Dr. 17349 USA Page 1 and 2 should be filed within 72 hours after death \text{ment of Health and Mental Hygiene.} ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muy or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Black White etc by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 XWidowed 4 ☐ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baker Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leslie Bostic Alli Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian K. Wachter-son 50 Stone Ridge Dr., New Freedom, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once, 3/17/12 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem 21. Signature of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Home 21157 Main St., Westminster, MD Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Renal Failure disease or condition resulting in death) Week Medical Examiner Weeks Sepsis From Urinary Tract Infection Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence on as the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE nse s yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No detached the 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page certificate 2 🗌 No 1 🗌 Yes Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Dove 2 XNo ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred After 28c. Injury at House 1 X Natural injury 5 Pending work?
1 Yes 2 No death. Accident Investigation in by the within 24 hours after deat

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed Month, Day, Year) 66 2012

(h)

Registrar
DHMH 17 Rev 06-2011

State

AVENUE

WESTMINSTER

MARYLAND

STONER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

291

THOMAS GALVIN

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08 Day Charles E. Walker 03^{Month} Medical 2012 0538 М 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince Georges **Funeral** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 1 Months Days 587-38-7205 Director 62 Hours Min 0877971949 Mississippi Usual Residence of Decedent or 28a-f show e notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Howard Co. Jessup 1 🗌 Yes 2 🙀 No 10e Street and Number items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 8409 Balsawood Lane 20794 U.S.A. 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 3 Divorced 1 Yes 2 No Specify: Completed Specify: Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 16b. Kind of Business Industry
Dept. of Youth Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Counselor Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Balsawood(wife) 8409 Balsawood Lane, Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) on-site Crematory 03/15/12 | Baltimore, MD 21. Signature of Funeral Service Licenses 210 SephdreH. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 ance 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Pericardial Effusion With Tamponade Onset and Death Week disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis 1-2weeks Sequentially list conditions if any leading to in mediate Examiner Due to (ar as a consequence of). cause. Enter Underlying Cause (Disease or iinjury Pneumonia been signed by the attending physician and should be detached for use as the burial-tran 1-2weeks that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo Pregnant at time of death 5 Other (specify) Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? End Stage Liver Disease Completed 1 Tes 2 No 3 Probably 4 Unknown Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performed death? 1 ☐ Yes 2 🔀 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Director: 1 ☐ Yes 2 ☐ No Investigation М 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FENDIN G Sound DIXYSIC IM D0057216 March 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Baako MD, 3450 Ft. Meade PO #209, Laurel, MD 20724 31. Date filed (Month, Pay, Year)
MAR 1 6 2012 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 12:17P • M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March P0, 20 T 2 Leroy Warnick Vernon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Gilchrist Care Center</u> Towson Baltimore . Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign Funeral 218-01-3217 Months Days Hours Min. September 1 🛮 M 2 □ F **Director** 93 Yrs. Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1705 Pinewood Drive 21222 U.S.A. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 ☐ Never Married 2 🛣 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Mechanic should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luther Warnick Edna Paugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Marie Warnick 1705 Pinewood Drive Dundalk, Maryland 21222 Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Page 1 March 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 13, 2012 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Kaczorowski Funeral Home, PA M00933 DR 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Starye Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any hading to immediate cause. Enter Underlying Due to jor as a consumence of Examir Cause (Disease or injury that initiated events and-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) ed by the a Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Wonknown Were autopsy findings available 24a. Was an has autopsy performe prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 140 ျပ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 24 hours after death.
Funeral Director: After tetely filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural Accident injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

comple Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

ARATHT

MD

NClu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

2. Registrar's Sign

71040

St Suite

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		-	For State Registrar	State of Maryla	·	artment o rtificate o		and ivi		Reg. No.	201	2 08247	
	Physicia Medic		1. Decedent's Name (First, Middle, Las	YOUNG	C				2. Date of Dea	ath	ا گاھے۔	3. Time of Death	
	Examin		4a. Facility Name (if not institution, give		t Hospi	4b. City, Town	n, or Location Randa		own		County of Dea		
	Funeral Director		5. Social Security Number 6. Se		rs. last birthday) Yrs.	If Under 1 Ye Months Da	ear If Under	r 24 Hrs.	8. Date of Bird (Month, Da Sept. 1	h y, Ye <i>ar)</i> 6 <b>,</b> 1 9	9. Bin Co Ma	thplace (State or Foreign suntry) ryland	
	yland f show ed at	tor	10a. State 10b. County		City, Town or Lo			1				10d. Inside City Limits	
	he Mar or 28a- or otifie	Funeral Director	Maryland  10e. Street and Number	1	Baltimo	ore 10f. Zip Cod	le			10g, Citiz	en of What C	1 X Yes 2 □ No ountry?	
	n with the ris 23a o	neral	2001 Ridgehill	Avenue		212	1 7			USA	<u> </u>		
036	s after death ral", or item Examiner n	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates.		Was Decedent of If Yes, specify C 1 ☐ Yes 2 🛣	uban, Mexica	n, Puerto R	ify Yes or No- lican, etc.)		4. Race - Ame Black, Whit ipecify: Bla	te, etc.	
21215-0036	ould be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", ar items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th Grade		(Give life. E	dent's Usual Oc kind of work do OO NOT use retir	ne during mos red)	st of workin	g		16b. Kind of Business/Industry Pharmaceutical Co.		
nd 2	filed w tal Hygi d other event, t	To Be	17. Father's Name (First, Middle, Last)				18. Moth		(First, Middle,	Maiden Si	urname)		
Maryland	should be file n and Mental I 7 is marked o raumatic eve	۲	Clarence Young  19a. Informant's Name/Relationship (Ty	roe Print)	10h Maili	ng Address (Str			Smith	r City or T	own State 7	in Code)	
, Ma	and 2 shu Health an tem 27 is		Elaine Harris/		1							0.21223	
Baltimore,	- # E 0		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Romoval from State	b. Place of Dispo	osition (Name of matory or other	place)	D	ate	20c. Loc	cation - City o	r Town, State	
Balt	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licens	Ham								neral Home	
	Physician/	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition										Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):		-						
	p tie	niner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of):								
	cate be executed physician and s the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons									
760	cate be physic the b	ledical		d									
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown			2	3d. Date of de Month	elivery Day Year				
ls, P.O.	uires that the n signed by uld be detac	b	Part II, Other significant conditions co	ontributing to death but not	resulting in the	underlying caus	e given in Parl	t I.				o the cause of death?	
Division of Vital Records, P.O.	The law requate has bee page 2 short	Completed							24a. Was autoj perfo 1  Yes	osy ormed?	prior to death?	utopsy findings available completion of cause of es 2 \( \square\) No	
/ital	sician: certific	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	EB/Outrotio	_	Other:		only one)	d 6 l	ho	spig	
on of V	nding Phy ath. r. After this ne funeral d	Certificate: To	27. Manner of Death  1 2 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year	28b. Time o	28c. I	njury at work?	2	8d. Describe			city) /	
Division	tal or Atte rs after de al Directo led in by th		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		reet, factory, off	ice	2	28f. Location (\$ City or Tov		Number or Ri	ural Route Number,	
	he Hospi in 24 hou he Funer pletely fil	Medical	(Check 2 Medical Exami	sician: To the best of my kr ner: On the basis of examin e Practitioner: To the best	ation and/or inves	stigation, in my o	pinion, death of	occurred at	the time, date a	and place, a	and due to the	cause(s) and manner stated.	
	Vith Vom		29b. Signature and tale of pertifier	TRAM	n	29c. Lic	ense number	27	2	1 -	signed (Mon		
,	1		30, Name and address of person who de the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se	completed cause of death (	Item 23a) (Type,	Print)	<u> </u>	Dl.	1 6	1 6	Jupin	21061	
H	Sta Registra		31. Date filed (Month, Day, Year)  MAR 1 6 2012	2. Registrar's Si	gnature Secr	Ked		· > / V(	· · · · · · · · · · · · · · · · · · ·	7	-10071		

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amend item 23a per doc 9925 3-16-12 yt
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month Physician/ Marcella Yeaple 2:20 March 8. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 7424 E. Furnace Branch Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Min 216-44-6280 64 **Director** 1 □ M 2 🛛 F Dec. 30,1947 Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States Apt 5 21060 7424 E. Furnace Branch Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homeowner Homemaker permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie mportant: If item 27 is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stella Bowen Howard Herron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Yeaple/ Husband 7424 E. Furnace Branch Rd. Apt 5, Glen Burnie,MD 21060 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/13/2012 Glen Burnie, Maryland Glen Haven Mem. PK. 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home
421 Crain Highway, SE, Glen Burnie, Maryland 21061 21. Signature of Fuperal Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Liver Disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami physician and s the burial-transil Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No n 24 hours after death.

e Funeral Director: Aft etely filled in by the fun Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my principle of the cause of examination and/or investigation in my principle of the cause Medical 29a. Certifier 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39505 Hospital Dr, Glan Burnie, MD. 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 205 1. Date filed (Month, Day, Year)
MAR 1 6 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cei	rtificate of D	Death	,	Reg. No.	112	08249
П	Physicia	n/	Decedent's Name (First, Middle, Last)     Frances Aldean Zeller	-	<del>-</del>		2. Date of De Month		Year 2012	3. Time of Death <b>6:07 A</b> M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea	Marc		y of Death 11timo	
			Stella Maris  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Timon If Under 1 Year	<b>1 um</b> If Under 24 Hr	s. 8. Date of Bir			
	Funeral Director		258-22-4798 1 M 2 🔏 F	88 Yrs.	Months Days	Hours Min	n. (Month, Da	ıy, Year)	Coun	**
	nd how at	'n	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		March	23,1923		abama  10d. Inside City Limits
	Maryla 28a-f s otified	recto	MD Baltimore	Cat	onsville					1 🗆 Yes 2 🛂 No
	th the 3a or 2 t be no	ral Di	10e. Street and Number	L 116	10f. Zip Code 212	20		10g. Citizen of		ntry? tes of Am
	eath w	-une	11. Marital Status 12. Was Decedent E	ot 116 ver in U.S. 13.	Was Decedent of Hi	spanic Origin? (	Specify Yes or No-		ce - Americ	
36	after d al", or i xamin	Completed by Funeral Director	1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 M If Yes, Give 1 Year or Dates.	No	If Yes, specify Cubai 1 ☐ Yes 2 🙀 No		rto Hican, etc.)	Bla Specify	ck, White, o	
2-00	hours natura dical E	olete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation		16b. Kind of B		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)  Charles Zeller (Son)	19b. Mailii 8159	ng Address (Street a Glan Gar	and Number or F y Road	Rural Route Numbe Baltim	ore, MD	3tate, Zip 0 21234	Code) 4
ore,	je 1 and t of Hei If item or othe		20a. Method of Disposition 1    ↑ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo	natory`or other place	e)	Date	20c. Location	•	
Itim	nit. Pag artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		e Memorial 1					Maryland
Ba	Depar Impor any in		Illabeth Grof	1- "	Gary L. K 7250 Wash	aufman ington	Funeral Blvd., E	Home at 1kridge,	MMP, MD:	1nc. 21075
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final	the death. Do not ent	er the mode of dying	g, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between
	Physician/ Medical		disease or condition END STA	GE CARDIA( consequence of):	DISEASE				_	Onset and Death
	Examiner	<u>_</u>								
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8760	ate be physici the bu	edica	d							
9	Attending Physician: The law requires that the death certificate be executed er death.  sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-trans.		IF FEMALE: 23b. Was decedent pregnant in the port 12 months?  23c. If yes, outcome of 1 □ Live Birth 2	of pregnancy	☐ Ectopic pregnanc			23d. Da	ate of delive	əry
Вох	t the death by the atte	Physician/	in the past 12 months?  1 ☐ Yes 2 🛣 No 9 ☐ Unknown			у		Mo	onth	Day Year
P.O.	es that the		Part II. Other significant conditions contributing to death but	t not resulting in the υ	ınderlying cause giv	en in Part I.	23e. Did t	obacco use cont	ribute to th	ne cause of death?
	requires been sig should b	ted t					. 1 🗆	Yes 2 ☐ No	3 🗌 Prob	bably 4 🗌 Unknown
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o uc	ttending F death. stor: After i	icate	27. Manner of Death  1   X Natural 5 □ Pending 2 □ Accident Investigation  28a. Date of injur (Month, Day,	y 28b. Time of Year) injury	work		28d. Describe I	now injury occurr	ed	
Division	l or Atter after deg Director d in by th	Certificate:	3 Suicide 6 Could not be	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S	Street and Numb	er or Rural	Route Number,
Ö	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical (	29a. Certifier 1 Certifying Physician: To the best of r	ny knowledge, death o	occurred at the time	, date and place	, and due to the c	ause(s) and mani	ner as state	ed.
	the Ho hin 24 l the Fui npletely	Med	(Check 2 Medical Examiner: On the basis of ex only one) 3 Certifying Nurse Practitioner: To the	amination and/or Inves	tigation, in my opinio , death occurred at th	n, death occurred ne time, date and	d at the time, date a	and place, and du the cause(s) and r	e to the cau	use(s) and manner stated. stated.
	vit To		29b. Signature and title of certifier	10 10	29c. License	number 3027	a	29d. Date signe	d (Month, L	)ay, Year)
			30. Name and address of person who completed cause of de	ath (Item 23a) (Type, F		1001	<u>ν</u>	-/13	10	10101
Y	) V Stat			300 DULANE		RD. TI	MONIUM,	MD 2109	93	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 2012 Physician/ 11:20P M Kathryn Anne Adkins March 5, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Mechanicsville** St. Mary's 27410 Fred Lane If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Days Hours **Director** 214-68-8198 1 M 2 X F 58 Maryland 08/14/1953 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No <u>Maryland</u> St. Mary's **Mechanicsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27410 Fred Lane 20659 USA within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White "natural" Completed 3 🗌 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Pharmacy Pharmacist Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Francis Ira Yates Marjorie Ann Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a tant: If item 27 is jury or other tra 27410 Fred Lane Mechanicsville, MD 20659 Ronnie Dale Adkins/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
one e. 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/10/2012 Helen, Maryland Queen of Peace 22. Name and Address Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Canter disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner one year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). resulting in death) Last physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 ding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital 2 X No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ours after death.

leral Director: Aft
filled in by the ful Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-9-2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Minal M. Shah, MD 23415 Three Notch Road California, MD 31. Date filed (Month, Day, Year) Registrar's Signat

Registrar

MAR 0 9 201

12-01192 Barry Adams

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		•	Certifica	ate of	Deat	h			F	Reg. No.			
Physicia	in/	Decedent's Name (First, Midd								2	. Date of De Month		Yea	ır	3. Time of Death
Medical Exami	ner	Barry Donal									Month February				1050 hrs
		4a. Facility Name (if not institution		nd number)		4			Location of	of Death			c. County o Baltimor		
	-	906 Fairmount Avenue Towson  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2									9. Data of B				
Funeral Director		Months Days Hours Min.										MM/DD/YYYY) 9. Birthplace (State or Foreign			
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ylanc t onc	흱	10e. Street and Number	CIMOLE	3	Tows	on T	10f. Zip	Code			-	10a Cit	izen of Wh	at Cour	
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5-0 Hygie	ន	17. Father's Name (First, Middle							18.Mother	's Name (I	irst, Middle,	Maiden	Surname)	)	77
121 l be fi ental urked vent,	æ	Donald Lest									aith				
should Marie astice	리	19a. Informant's Name/Relations						•			ral Route Nu		•		'
10re, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	- 1	Donald Adams 20a. Method of Disposition	/ Fat	ner	20b. Place o	/1 D	r.	Mil	ler		Nort Date	h E	ast,	MD City or	21901 Town, State
S la of He of He		1 X Burial 2 Cremation	n 3 🗌 Remo	val from State	cremate	ory or othe	er place)							•	,
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	-1	23a. Part I. Enter the disease, or	complications	hat caused the	death Do no	1 11	1 S	f dvinā	ueen	ST ardiac or r	Pic	ing	Sun	M	D 21011 Approximate In erval
Physician		failure. List only one cause	on each line.	\		COMOT UT	, mode c	dynig,	3441 43 0	ai diac oi i	copilatory at	1031, 311	Jorg of Flob		Between Onset and Death
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Tospit 4 hour buners		29a. Certifying P	hysician: To th				-	time da	ite and nia					-	
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Oncor only	miner:On the b	asis of examin											
r vit	¥ĕ.	29b. Signature and title of certific		ner stated.			290	License	e number			29d.	Date signe	ed (Mon	th, Day, Year)
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-	ŀ	30. Name and address of person	who completed	cause of deal	th (Item 23a)							1			
54141			nt Medical I			altimore	Stree	t, Balt	imore, N	MD 212	23				
St	ate	31. Date filed (Month Luay, Year)	2012 3	2. Legistrar's	Signature	par	41								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. 2<u>012</u> Physician/ Feb 22. 0130 Athev **Edith** <u>Mae</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Allegany Health Nur. & Rehab. Ctr. Cumberland 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Social Security Number 6. Sex Age (In yrs. last birthday) 1 DM 2 D Apr 10 Director 214-34-1775 75 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Allegany Cumberland 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21502 730 Furnace Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 ☐xWidowed 4 ☐ Divorced white Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Athey's Laundrymat owner / operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nellie Poland Herbert Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 E. Florida Way

Lonaconing

MD

21539 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Pansy Blacker daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Sunset Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 2/24/2012 MD Cumberland Conation 5 C Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e ch line Immediate Cause (Final Pnysician/ Your disease or condition Medical resulting in death) Due to (or as a consequent of) **Examiner** Sequentially list conditions it any hading to in midial cause. Enter Underlying Exami Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ed by the g Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown has been signed by the second 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed page certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; Afcompleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of c 00633280 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Ste. 101 aumberland, MD 21502 nas M. R Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Monique Williams Ampah 20 04:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury Wicomico Peninsula Regional Medical Center If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min 1 ☐ M 2 🖾 F 113-52-1724 49 Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once. 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No New Church VA Director Accomack 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23415 USA 29313 Tyler Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. Specify: ð Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Williams James Clark ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Markeith Williams / Son 29313 Tyler Dr., New Church, VA 23415 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3r□ Removal from State St. John U.M. Cemetery 3/3/2012 Atlantic, VA 4☐<del>Don</del>ation 5☐Øfher (Specify). 22. Name and Address of Facility 121 Sonature of Fune A S amulo Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final **Physician** Monary disease or condition resulting in death) /Medical or as a consequence of): Examiner sif any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1∐Yes 2¶Mo Ö the detached 9 Unknown signed by t ď. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has l lirector, page 2 s autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 M ER/Outpatient 3 □ DOA 1 Inpatient ဂ္ this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Hospital or Attending 5 Pending Investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30 death (Item 23a) (Type, Print) 30. Name a 31. Date filed 32. Redistrar's Signature State EB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 02/24/2015ar Physician/ 10:40 A M Gazelle Black Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday **Funeral** Months 229-46-9643 **Director** 1 M 2 X F Yrs 73 04/11/1938 VΔ items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Prince Georges Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1353 Southview Dr., apt. 102 20754 AZU within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. , o ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: If Yes Give "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bossie Black Mozelle Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Gloria A. McGee / daughter 3453 Minnesota Ave., SE, Washington DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State alo Ch. Cem. 103/04/2012 Nathalie, VA 22. Name and Address of Facility Strickland Funeral Services 4 Donation 5 Other (Specify 2nd Buffalo Ch. Cem. any injury 21. Signature Funeral Service I center 6500 Allentown Rd., Camp Springs, MD 20748 Pad. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT Physician/ disease or condition Medical resulting in death) **Examiner** HEMORRHAGE INTRACEREBRAL Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo 5 Other (specify) Pregnant at time of death the 8 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE STAGE KIDNEY 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of After this certificate has To the Hospital or Attending Physician: The I. within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 1 ☑ Inpatient 2 □ မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: **V**atural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2/24/2012 D0064986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar

MAR 0 82012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ 17:21 M 2012 Tyrone Lamont Bacon Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Cheverly Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year) 579-72-8557 **Director** 1 🖾 M 2 🗆 F 55 5 21 1956 DC Usual Residence of Decedent show 10a, State 10d. Inside City Limits at 10c. City. Town or Location Director notified 28a-f 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n ms 23a or must be r by Funeral 4704 Nash Street NE 20019 United States an "natural", or items Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. If Yes, Give 3 Divorced Completed Year or Dates **Black** Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than h and Mental Hygiene.
7 is marked other than traumatic event, the M life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Printing Plant Work Leader 12th Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Health and Menta item 27 is marked other traumatic e Horace Bacon Thelma Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2206 Wooded Way Huntingdon Pennsylvania 16652 Tyrone Anderson/Son other 20a. Method of Disposition
1 □ Burial 2 ঐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Filmportant: If ite any injury or ot 4 Donation 5 Other (Specify) Chesapeake Crematory 3-6-2012 Beltsville, Maryland Sanature Funeral Service Lig 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ FATAL CARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be
 24 hours after death.
 Funeral Director: After this certificate has heen sinned by the attendion hours. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the attended for us 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 L Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown been sig 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 2 completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X/10 ျှ 1 🗌 Yes 1 Inpatient 2 R/Outpatient 3 DOA Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Examination of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signatur d title of **p**erti 29d. Date signed (Month, Day, Year) FEBRUALY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

JAMES

31. Date filed (Month, Day, Year)

MAR 0 52012

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HOSPITAL DLIVE

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year 2012 JEAN JOYCE BROWN MARCH 4:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 148-28-6108 **Director** 1 □ M 2 X F 78 SEPT 24, 1933 **VIRGINIA** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director be notified 1 X Yes 2 □ No MD **CHARLES** SWANN POINT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral must l 14800 KING CHARLES DRIVE 20645 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: BLACK "natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ NURSING ASSISTANT HEALTH CARE traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | ည WILLIAM HENRY BROWN BEATRICE REED BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 DIONNE JAMES/DAUGHTER <u> 14800 KING CHARLES DRIVE, SWANN POINT, MARYLAND 20645</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hambortant: If ite any injury or ot 1 🗶 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HERITAGE MEMORIAL CEMETERY MARCH 8, 2012 WALDORF, MARYLAND ture of Funeral Serv THORNTON FUNERAL 3439 LIVINGSTON L HOME, P.A. ROAD, INDIAN HEAD, MD 20640 EYDIA C. THORNTON JOHNSON/M00583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final MULTIORGAN FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** SEVERE SEPSIS Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit CHRONIC OBSTRUCTIVE PULMONARY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Ď Pregnant at time of death 5 Other (specify) Unknown g Unknown P.O. b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown LUNG CANCER, DIABETES MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION, OBSTRUCTIVE SLEEP APNEA 24a. Was an autopsy performed?

1 Yes 2 No has 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 🗆 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify, Hospital မ 1 Inpatient 2 XER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pendina 2 Accident Investigation within 24 hours after death

To the Funeral Director: / Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Hospital Medical 29a. Certifier 🟋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuous Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signi 29d. Date signed (Month, Day, Year) 29c. License number 03/01/2012 D37174 address of person who completed cause of death (Item 23a) (Type, Print)

State

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31. Date filed (Month AR

CHON, M.D.

5 2012

Registrar

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7C POST OFFICE ROAD, WALDORF, MARYLAND 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ MARCH 8:50 A AVON LOWELL BLAND Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** RESIDENCE. 5325 SMITH DRIVE **CHARLES** INDIAN HEAD Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 62 **Director** 216-50-9090 1 **X** M 2 □ F JUNE 15, 1949 WASHINGTON.D.C. Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10a. State 10b. Count 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No MARYLAND CHARLES INDIAN HEAD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 5325 SMITH DRIVE 20640 UNITED STATES within 72 hours after death 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status "natural", or iter dical Examiner Black, White, etc. Armed Forces' 1 Never Married 2 Married 1**X** Yes 2 ☐ No. If Yes, Give δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. 2 YEARS College (1-4 or 5+) Elementary/Secondary (0-12) CARPENTER FEDERAL GOVERNMENT Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) nd Mental F marked o မ ARTHUR RANDOLPH BLAND RUTH ELIZABETH WASHINGTON BLAND MAYO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is m 19a. Informant's Name/Relationship (Type, Print) Health a CYNTHIA M. BLAND / WIFE 5325 SMITH DRIVE, INDIAN HEAD, MARYLAND Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) MARYLAND VETERANS CEMETERY MARCH 9, 2012 CHELTENHAM, MARYLAND Signature of Funeral Service hicensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN LYDIA C. THORNTON JOHNSON MOO583 HEAD MARYLAND 20640 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final once Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? φ Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 A 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No ☐ Accident Investigation after death Director: / by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 ... within 2

To the I

comple only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar
DHMH 17 Rev 06-2011

State

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KRISHAN MATHUR, M.D.

31. Date filed (Month, Day, Year) MAR 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. BOX 2729, LA PLATA, MARYLAND

D28352

MARCH 2, 2012

20646

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O3 Physician/ 2012 Verna Disney Brenner 4a Facility Name (if not institution, give street and number) Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** omico -ocistal Hospice bur Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 X F VA **Director** 213 05 2019 8/1/1917 94 Usual Residence of Dece 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location Director 1x Yes 2 ☐ No Ocean City MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 21842 108 120th St. #42 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: white 3 X Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) own home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) മ Florence Isabell Atkinson Herbert Disney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ocean City, MD 21842 108 120th St. #42 Nancy Fortney (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Perryhawkin Cemetery 3/5/2012 Princess Anne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home Service Lices 21. Signatur 108 William St. Berlin, MD 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between 23a. Part 1. Onset and Death Immediate Cause (Final BMBNT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter chaothing Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death sate has been signed by the spage 2 should be detached 1 L Yes 2 P Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 NO 1 🗌 Yes 1 Yes certificate 26. Place of Death (Check only one) Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 1 Yes within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at work?
1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Manner of Death Certificate: 5 Pending Natural 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

Registrar

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			1 - For State Registrar	State of Ma	aryland / [		artment of H <i>tificate of L</i>		and Mental I		ene 🖰 🔌 g. No.	/ 1 hm	00200
			Decedent's Name (First, Middle, I	ast)					2. Date o				
н	Physici		DONALD	L.	BRITTI	NGHA	ΔM		FEB	1	Day 1	2012	14:21 P ^M
7	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location o	f Death		4c. Cour	nty of Death	
			7 SMITH ROAD				ELKTON				CECI	L	
	Funeral		5. Social Security Number 6		e (In yrs. last bir	rthday)	If Under 1 Year Months Days	If Under a		f Birth	(ear)	9. Birthpl	ace (State or Foreign
	Director		209 60 1204	1 X M 2□ F	55	Yrs.			SEPT	5,	1956	Comb	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation					10	Od. Inside City Limits
	sho	5	MD CECII		ELKTON								1 ☑ Yes 2 ☐ No
	the A	Director	10e. Street and Number		ELKIOI	N	10f. Zip Code			100	a Citizen a	of What Coun	<u> </u>
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I're Medical Examinar must be notified at once.	ai Dir	7 SMITH ROAD				21921			10,	USA	A TTHE COURT	
	ems	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of His f Yes, specify Cubar	spanic Orig	gin? (Specify Yes o	r No-		ace - America	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 [X]			1 □ Yes 25√2 No	Specify:		,	Spec		
Maryland 21215-0036	hour tural		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	160	Doore	ient's Usual Occupa	tion		14	Sh Kind of	Business/Inc	
5	in 72 n na	Completed	(Specify only highest	rade completed)		(Give	kind of work done d OO NOT use retired)	u <i>ring</i> most	of working	"	bb. King or	Dusinessine	ustry
7	with iene.	mo	Elementary/Secondary (0·12)	College (1-4or 5		LESN				E	NVTRO	MENTAL	
Ö	filed Hyg othar ant,	a l	17. Father's Name (First, Middle, La		JAI		Dil.	18. Mothe	r's Name (First, Mi				
<u>a</u> n	lid be lental kad kad ic ev	To B	LAWRENCE BRITT	INGHAM				JEAN	LoMAX				
ary	shound N	_	19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailir	g Address (Street a	nd Numbe	r or Rural Route No	umber,	City or Tow	m, State, Zip	Code)
Σ	alth alth 27 is ar tra		JACQULYN BRITTIN	IGHAM	7	SMI	TH ROAD,	ELKT	ON, MD 21	921			
ore.	of He of He ritam		20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of natory or other place	) F	EB 18,			n - City or To	wn, State
Ĕ	Page ment ant: It arry o		1 XX urial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		HEAD	PERS	CHRISTIANA	A 2	012		NEWAR	K, DE	
Baltimore,	Depart Depart mports my inj		21. Signature of Funeral Service Lic	un k			. Name and Addres IEALEY FUN						
			23a. Part1. Enter the disease, or co		00784		O BOX 286					5-0866	Approximate
			shock, or heart failure. List on Immediate Cause (Final	y one cause on each li	ne. A			01	)			4	Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. Metast	atric s		amous	all	Carcini	om	~ ~	arth	
	Examiner			Due to (or as	a consequence	00	rigin w	te.	metal			500.0	1
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of):	rigin	1 100	10,001	C> (;	> 10	Spine	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				7.9						
Ć,	exec n and ial-tra	Еха	resulting in death) Last	Due to (or as	a consequence	of):	10/11/2011				- C 100	=2.1	
68760,	icate be executed physician and s the burial-transit	edicai		d									
_		ledi											
Вох	h cer endin	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 -	Ectopic pregnancy					Date of delive	•
	The law requires that the death certil tie has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (specify)				N	Month	Day Year
о. О	at the by the	hy	9 🗆 Unknown								1		
	es the de	by	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the ur	nderlying cause give	n in Part I.					e cause of death?
D.C	equition s	Completed								1 ∐ Yes	2 □ No	3 🗌 Proba	ably 4 Unknown
Ö	2 2	pje							8	Was an		o. Were autop	osy findings available inpletion of cause of
<u>~</u>	The ate h page	Con							1 🗆 Y	es 2	ed? Sylvo	death?	2 No
<u>=</u>	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					26. Place	of Death (Check o	nly one,	)		
<u>&gt;</u>	hysid	2	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatie	ent 2□ER/Ou	utpatien		4 🗀 NU	rsing Home 5 🗡	esiden	ice 6 □C	ther (Specify	)
בַ	ing P	on:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. 1 y Year) I	Time of Injury	28c. Injury Work		28d. Descr	ribe how	v injury occ	urred	
Sio	tand leath. tor: A	cati	2 Accident investigat 3 Suicide 6 Could not	he				′es 2⊡i	-	10.			
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	4 Homicide determine		ury - At home, fa c. (Specify)	arm, str	eet, factory, office			on (Stre r Town,		mber or Hura	l Route Number,
	spita hours unaral y filled		29a. Certifier 1 Certifying	Physicien: To the best	of my knowledge	e, death	occurred at the tim	e, date an	d place, and due to	the cau	use(s) and i	manner as st	ated.
	tha H in 24 tha Ft pletel	Medicai	one)	eminer: On the basis of and manner sta	ated.	or in			un occurred at the ti				
	To t To t	Σ	29b. Signature and life of certifier		W	D	29c. License	number	-0101	290	d. Date sign	ned (Month, I	Day, Year)
•				-			C1-	00	07126		2	15/1	2
	12		30. Name and address of person wh	o completed cause of d	leath (Item 23a)		411	4	4/01 NJ	داره	, Ki	DEI	971
	Sta	te	31. Date filed (Month, Day Year)		ar's Signature	1	and act Ort	ive.	10170		-, ( )	VEL	1115
	Registr		FFH I D Z	112 /2 Num	4 1	Made	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month 201 Medical Facility Name (if not institution, give street and number) 4b. City. Toy Examiner 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months 222-28-4289 Hours Director 1 🏻 M 2 🗆 F 66 01/20/1946 DE 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director DE New Castle Wilmington 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 23a or 10g, Citizen of What Country? Funeral 1337 Sycamore Avenue 19805 USA items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?
1 

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō within 72 hours after þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sheet metal worker Amtrak Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I. Important: If free Z7 is marked any injury or net-ည Franklin Buckalew Mary Beatrice Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia D. Buckalew / daughter 1337 Sycamore Avenue, Wilmington DE 19805 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Delaware Veterans Memorial Cemetery 1 K Burial 2 Cremation 3 Removal from State 02/16/2012 Bear, DE 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Family Funeral Home 635 Churchmans Road, Newark, DE 19702 21. Signature of Funeral Service Lio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to (or as a consequence of, cause. Enter Underlying Examin sician and burial-transit executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at Id be detached fo Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown P.O. Part U-Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate .2 No 1 Yes Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) Inpatrent 2 X No Hospital 1 Yes ဂ္ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Cother (Specify) 1 Inpatient 2 I After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1/X Natural 5 Pending I Director: At d in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title icense numi 29d. Date signed (Month, Day, Year) Name and address ath (Item 23a) (Type, Print) CONSI Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Menth Physician/ Donald W Bollinger Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min Director 215-36-8721 1 X M 2 D F December 15, 1934 Maryland Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 203 Maple Place 10g. Citizen of What Country? Funeral 21532-U.S.A. or items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rica by 1 X Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: and Mental Hygiene. is marked other than "natural", If Yes, Give Specify: 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Culinary Server Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Unknown Helen M. Bingaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Doris Lillard Aunt 12 Federal Street Maryland 21532-Frostburg Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State **Cumberland Crematory** February 29, 2012 Cumberland Maryland 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 5121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cerebrousscular disease or condition day Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Unknown g 🗌 Unknown Division of Vital Records, P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No Urinary Tract Infection 3 Probably 4 Unknown Supraventricular Tachy cardia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Lewy Body 3 25. Was case referred to edical Dementio 2 No Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of certifier use of death (Item 23a) (Type, Print).

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,
State of Maryland / Department of Health and Mental Hygiene

			1 - State Certificate of Death Reg. No.									
			Decedent's Name (First, Middle, Last)			2. Date of Death						
	Physicia		BETTY LEE BENNETT			Month 02 2	Day Year 2012	8:25 A.M				
printer.	Medic Examin		4a. Facility Name (if not institution, give street ar	nd number)	4b. City, Town, or Location of Death	1 0= 1	4c. County of Death	0,92,11				
	Examin	ler	32618 National Pike		Little Orleans		Allegany	,				
5-47-00	Francis		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign				
	Funeral Director		1 □ M 2	□XF   Vre	Months Days Hours Min. (Month, Day, Year) Country							
			236-44-9831 Usual Residence of Decedent	81 118.		10.5/2.5/19.5	west.	<u>Virginia</u>				
	and shov	٥	10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits				
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	or 28	۵	10e. Street and Number		10f. Zip Code	10g	10g. Citizen of What Country?					
	vith t	ral	709 Elm Street		21502		U.S.A.					
	ath v	Funeral Director	11. Marital Status 12. Wa	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Americ	an Indian					
(0	or its	by F	Arm	led Forces? Yes 2 <b>X</b> No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,					
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	ğ	3 X Widowed 4 □ Divorced If Yea		Specify: Whi	te						
9	hour natur lical	lete	15. Decedent's Education	b. Kind of Business Inc	dustry							
꿏	372 an "l	3 Na Widowed 4 Divorced Pear or Dates.  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surmame Rosa Jane Reed  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, STOP)  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location - Date 20c. Location										
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ē,	f Heal item		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date 20	c. Location - City or To	wn, State				
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B	permit. Page 1 a Department of I Important: If it any injury or of	eral Home, land, MD	21502									
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ğ	require been s should	etec										
8	law r has b ge 2 sh	ğ				24a. Was an autopsy	prior to co	psy findings available mpletion of cause of				
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taj	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?		26. Place of Death (Che	ck only one)		E				
>	hysic his c	은	1 LJ Yes 2 Z No	1 Inpatient 2 ER/Outpatie		lome 5 Residence	e 6 X Other (Specify	friend's				
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	Hosp 24 ho Fune rted fi	Medical	(Check 2 Medical Examiner: On	the basis of examination and/or inves	occured at the time, date and place, a stigation, in my opinion, death occurred	at the time, date and p	lace, and due to the car	use(s) and manner stated.				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certifical completed filled in by the funeral director, to	Ž	only one) 3 Certifying Nurse Pract 29b. Signature and the of certifier	oner: To the best of my knowledge,	death occurred at the time, date and pla							
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_	200		30. Name and address of person who complete	1	Print)	D 2150	17					
	nas			625 Kent Ave	Cumberland, M	11) 413	-1 -6					
	Sta	te	31. Date filed (Month Day, Year)	32. Registrar's Signature	Kland							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 08263 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Februar Physician/ 0700 Daymon Blake, 17, 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico ry Republication a Nursing Ctr. y Number 6. Sex 7. Age (In yrs. last of tholay) sburg If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 X M 2 □ F Months Hours 5-18-1935 76 214-34-7255 Yrs. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 S. Ross Street USA 21863 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed SpecifBlack 3 X Widowed 4 ☐ Divorced er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck <u>Driver</u> Hudson Foods is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Daymon Blake, Sr. Della Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya Sample/Daughter Covington Street, Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Coolspring UM Cem 2-24-2012 Girdletree, 21. Signature of Funeral Service Licensee Bennfire Ads fragility 917 W. Isabella St. Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Rel Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and the detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day Part II. **Oth<u>e</u>r significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h Completed filled in by the funeral director, page completed filled in by the funeral director, page performe 1 ☐ Yes 2 🗷 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AM 29505 02-17-2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO BELLOSO. 5302 CHINABERRY DR., SALISBURY MD 21801

Registrar
DHMH 17 Rev 7/2009

State

B 2 4

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fold Your Physician/ 32 KM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HURLOCK Villaga one 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🕱 F 08-15-1938 **Director** 214-36-7282 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No Md. Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 6219 Jones Village Road 21643 USA or items permit. Page 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner man Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: If Yes, Give Completed 3 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Janitor Firestone 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Otho Jones Daisy Ann Camper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6219 Jones Village Rd., Hurlock, Md. 21643 Roosevelt Boggs/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 02-29-12 Direct Dover, Delaware 4 Donation 5 Other (Specify) Crematory 22. Name and Address of Facility
Bennie Smith Funeral Home
516 S. Main Street, Hurlock, Md. 21643 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner PEGVS if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Pase matter Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: ၉ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at injury Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) FEB 28 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ^D24, Physician/ 2:09 Evelyn Mae Burns February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Days Hours West Virginia 1 □ M 2 🛚 Director 233-36-6712 June 88 Usual Residence of Decedent 10b. County 10d Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** or 28a-f sl 1 Yes 2 No Davidsonville MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 23a 21035 USA 2365 Rutland Rd. ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White "natural", 3 Midowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) r than ", Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. National Plastic 8 Assembler Department of Health and Mental Hygiei Important: If item 27 is marked other 1 any injury or other traumatic event, thouce. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elvina Jane Howard Fred Vance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 173 Harwood Rd., Harwood, MD 20766 William Telford Burns/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1XXBurial 2 Cremation 3 Removal from State Hillcrest Mem. Gards. 2/29/2012 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition Physician/ vermina Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Imjury Due to (or as a consequence of) use as the burial-transit **To the Hospital or Attending Physician**: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No for Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1-Natural 5 Pending ours after death.

leral Director: Af

filled in by the fur Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1005 7635

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

FEB27

2001

Amend#5,19A To AMEND#23a per PtryState of Maryland / Department of Health and Mental Hygiene State Registrar 2/27/2012 AACO HEALTH DEPT: CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2/20/2012 Physician/ 3:58 P M MARY LOUELLA BARTOS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 579–38–8566 **Funeral** (Month, Day, Year) 9/22/1930 1 🗆 M 2 🗶 F Months WASHINGTON D.C Director 81 570-38-8566 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 🛚 No MARYLAND ANNE ARUNDEL GAMBRILLS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 730 ROUTE 3 SOUTH USA 21054 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc δ 1 Never Married 2 Married Specify: WHITE Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT ADMINISTRATIVE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thent of Health and Mental Hi rtant; If item 27 is marked oth ijury or other traumatic even ဂ္ HARRIET E. MATTERN CHARLES C. BALL 19a. Informant's Name/Relationship (Type, Print) Theresa Bartos Eckert/Caughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 LAFAYETTE AVENUE ANNAPOLIS, MD 21401 Department of Health Important: If item 27 any injury or other th TERRI ECKERT/ DAUGHTER Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date CHESAPEARE CREMATION CENTER 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) /23/2012 STEVENSVILLE 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS.
HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE P.A Signature of Euneral Service License ROAD ANNAPOLIS BESTGATE 23a Fart 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Congestive Heart Failure Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner 10 Sequentially list conditions, Examine for as a nunsequence off cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last executed and burial-trar Due to (or as a consequence of): attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death asn 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Matural injury 5 🗌 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/20 pil2 72600 me ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cito 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ erine C. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Regional Hospital Prince Laure Laurel George's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** 1 🗆 M 2 🕱 F Days (Month, Day, Y Months Hours Min. 93 206-07-4369 Yrs. **Director** 1919 Ronco, Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director notified 1 🗌 Yes 2 🔀 No Prince George's Lanham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be 23a Funeral 20706 USA 9885 Greenbelt Road, Apt. 100 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner rmed Forces?

☑ Yes 2 □ No NAVY Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates. 1943–1946 Completed 3 X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Statistical Clerk 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Rolland Cole Caroline Bell Hensel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9865 Good Luck Rd, #5, Lanham, MD 20706 Viona I. Brown / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cheltenham, Maryland 3/2/2012 Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. RAY Roge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. i i n perstion disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. ter chaonying Examiner Due to (or as a consequence of). the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Pregnant at time of death been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be irector, page 2 s autopsy performe death? 1 🗌 Yes 2 🛂 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending s after death. Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide determined ⊆ within 24 hours aft

To the Funeral Di

completed filled in Medical 1 🖳 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 2 D54223 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital, Emergency Dept. 7300 Van Dusen State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g925 3-22-12 vt 16a,b, 19b State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#11,19a, per INF, C928,6/4/2012, WS

Certificate of Death

Reg. No. For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day Physician/ Karl Lamont Caldwell 1:30 P M 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Prince Georges Hospital P.G. Cheverly Social Security Nu9704 Birthplace (State or Foreign Country) Wash . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, Year) Min. Wash, Hours 577-98-<del>9</del> 46 Director 1 🌠 M 2 🗆 F 5-3-1965 D.C. 10d. Inside City Limits 28a-f show 10a. State 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director P.G. MD 1 Yes 2 X No Mitcheville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 1967 Beecham Ct. 20721 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever in U.S. 11 Marital Status Black White, etc. Armed Force 1 Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 †
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Market once. (Specify only highest grade completed) Government ife. Contractor
Contractor Elementary/Secondary (0-12) College (1-4 or 5+) Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Caldwell Nancy Glymph 2 19b. Mailing Address (Street and Number or Republicate Number Gityro Town, State, Zip Code)
1967 Beecham Ct. Mitcheville MD. 207 19a. Informant's Name/Relationship (Type, Print) Fiance Alando Burch (Wife) 20721 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-2-2012 Laurel MD. National Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral CC373 908 Kennedy St. N.W. 20011 Wash, 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, it is a production cause. Enter Underlying Physician/Medical Examiner Due to or as a consequence of executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death be detached the Linknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ြင် 2 A No Inpatient 2 ER/Outpatient 3 DOA this Manne of Death 28c. Injury at work? 1 🗌 Yes 28b. Time of 28d. Describe how injury occurred ate of injury Certificate: within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) injury 5  $\square$  Pending Natural 2 No Accident Investigation filled in by the 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 29d. Date signed (Month, Da 29b. Signature a sympleted cause of death (Item 23a) (Type, Print) and address of Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 08269 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fred Carson, III 28. February 2012 3:00 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 401 West Tantallon Drive Fort Washington Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign April 4 1 **X** M 2 □ F Days 577-70-3857 61 Yrs **Director** 1950 Washington, D.C. Usual Residence of Decedent 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location Director Fort Washington 1 X Yes 2 No Maryland Prince Georges 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral with. 23a 401 West Tantallon Drive 20744 United States items 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces? US Army
1 X Yes 2 NoAug.1969
If Yes, Give
Year or Dates. July 1972 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Black, White, etc ò δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", **Black** Completed 3 Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Prince Georges County and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) l year Bus Driver Schools System Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Lucille Sadie Bell Walker Fred Carson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Claudette Velma Carson (Sister) 401 West Tantallon Drive; Fort Washington, Maryland Baltimore, 2012^{20c. Location} 20a, Method of Disposition 20b. Place of Disposition (Name of - City or Town, State Cheltenham, March 8 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cheltenham Veterans Cemetery Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, a. Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 CC0333 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Kidney Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-trai Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 X Unknown Completed 1 Yes 2 No . Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? ↑ Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 X Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending injury work death. 1 Yes 2 No the 1 2 Accident
3 Suicide Investigation 6 Could not be 24 hours after deal Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or "ur-I Route" umber, determined City or Town, State) Hospital Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Koucetchou, M) JOCELYNE D63748 February 28, 2012

State Registrar

Date filed (Month, Day, Yea MAR 0 5 2012

Jocelyne Kouatchou, M.D.;4041 Powder Mill Road;Suite 600;Calverton,Maryland 20705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Signa

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ BETTY LOUISE CARROLL :05 a M March Medical 4a. Facility Name (if not institution, give street, and number) or Location of Death **Examiner** 4c. County of Death If Unde . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. Months Days 212-62-0435 **Director** 1 □ M 2**X**□ F 72 FEB 13, 1940 MARYLAND 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 275 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES NANJEMOY 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3110 POSEYTOWN ROAD 20662 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 2 1 Never Married 2 X Married ☐ Yes 2 🕱 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify. Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOUSEKEEPER HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNIE JOHNSON SAMUEL JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMAN CARROLL/HUSBAND 3110 POSEYTOWN ROAD, NANJEMOY, MD 20662 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify, OAK GROVE CHURCH CEMETERY 03/07/2012 NANJEMOY, MARYLAND in the of Funer I Cervice Lin THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 LADÍA C. THORNTON JOHNSON MOO583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cardiomyr disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner quantitally list earditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 L. retai acc...
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No 1 Yes ပ 1 Inpatient 2 LER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury_at 28d. Describe how injury occurred eral Director: After filled in by the funer t atural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D45737 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRMALADEVI JAYANTHAN M.D., 3328 OLD WASHINGTON ROAD, WALDORF, MD 20602 Registrar's Signa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and nur 4b. City Examiner Town, or Location of Death 4c. County of Death IN If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Fereign Country) **Funeral** Hours Min **Director** 1 🗆 M 2 💢 F 60 25-VIRGINIA 28a-f show 10c. City, Town or Location at 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No ō 10g. Citizen of What Country? items 23a Funeral 5. 20 death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1. Marital Status þ 1 Never Married 2 Married "natural", or 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black Specify: 3 - Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SPORTS ENTERTAINMAIT Sociat Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) ပ 995 -0415 arroll Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother 6000 Packla 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Phillip Rell Sr. & Winona Morrissetk 22. Name and Address of Facility Phillip Pell Sr. & Winona Monissette -Lonnson P. A. 2107 Carl Ct. Accokerk, M.D. 20607 21. Signature of Funeral Service Licensee Phillip 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ e5 DIVATOR Fail disease or condition resulting in death) Medical consequence of): Examiner my ocardia, Sequentially list conditions, Examine Due to (or as arconsequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Card To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar resulting in death) Last (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 m 1 Yes 2 ate has been signed by the atter page 2 should be detached for u Month Day Pregnant at time of death Unknown 9 Unknown Other significant conditions contributing to death but not resulting 23e. Did tobacco use contribute to the cause of death? Completed by 2S 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perfo death? mia 25. Wa case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: Invatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Medical Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 🗌 Yes after death. 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 012 PMD 7503 SUNAT 7503

State Registrar MAR 0 5 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27,2012 Gertrude Cseplo February 11:58 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles 4203 Sandwich Circle Waldorf 7. Age (In yrs. last birthday If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 098-16-5756 Days Hours **Director** 1 🗆 M 2 🗶 F Sep.25,1923 88 NewYork Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Charles Waldorf X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4203 Sandwich Circle 20601 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 □ Divorced Completed Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Moving and Storage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Burger Elizabeth Wendell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6148 Humpback Whale Ct. Waldorf, 20603 Kent Cseplo (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) US National Cemetery Mar.6,2012 | Calverton, NewYork 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Road Waldorf, MD. 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) # AFC Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 the a n signed by the funeral after death. filled in by the

Baltimore, Maryland 21215-0036

To the Hospital o within 24 hours af To the Funeral Di completely

State

Medical

reward

Suicide

4 Homicide

29a. Certifier

(Check

only one) 29b. Signature and title

6 Could not be

determined

who,completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

26)0

29c. License number

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year) 20112

100

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1517 ebruar 4 2012 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Social Security Number If Under Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Year) Months Hours Min. 1 □ M 2**X** F New Jersey 83^{rs.} Director 150-22-8600 11/08/1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Western Event in any both without any one. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 XYes 2 No **Funeral Director** MD Kent Chestertown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 108 School Road 21620 United Sattes Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Judiciary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ James Greenock Marian Sheilds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Chatellier / Husband 108 School Road Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation 03/02/2012 | Stevensville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. Fellows, Helfenbein & Newnam Funeral Home, P.A. tellerus 130 Speer Road Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE END STAGE 1 week /Medical Due to (or as a consequence of): Examiner HORTIC Rav STENIOSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ş 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗷 No 2 No 1 ☐ Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 \( \subseteq \text{ Nursing Home} \) 5 \( \subseteq \text{ Residence} \) 6 \( \subseteq \text{Other} \( (Specify) \) 1 Yes 2 No 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number 30 0004158 2012 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State		S	State of	Maryla		partment o <i>ertificate d</i>			Mental H		Z U 1	2 08	3271
		Registrar  1. Decedent/s Name	e (First, Middle	e. Last)		4		er inicate t	Dea	ui i	2. Date of D	Reg. N	lo.	3. Time	of Death
Physici		Antoin	ette	1)	DSED	hine	Ca	libeu			Month		129 20		45AM
/Medio		4a. Facility Name (I.	f not institution	, give stre	et and humi	ber)	106	4b. City, Tow	, or Locati	ion of Death	7		c. Gounty of D	eath	
		5. Social Security N	ER K	6. Sex	HOS	dtai	Last birth de	(he) If Under 1 Ye	teki	der 24 Hrs.	8. Date of B	irth	Kent	Birthplace (State	a or Foreign
Funeral Director		177-30-74	1111		2 <b>X</b> F	. Age (In yrs	74 Yrs.	Months Da			(Month, 1	Day, Yea	ir)	Country)	
		Usual Residence of	Decedent			10.0	ity. Town or	I anation			10/30	1173	,, ,,,,,	10d. Inside	
faryla f shov	ō	10a. State	10b. County				,								es 2 X No
r 28a-f show	Director	MD 10e. Street and Nur	KENT nber			RO	CK HAI	10f. Zip Coo	9	***		10g. C	Citizen of What	Country?	
th with	al D	6893 HAGY	ROAD					21661				UNI	TED STA	TES	
items	Funeral	11. Marital Status			Armed Ford	ent Ever in Ues?	J.S. 1	3. Was Decedent If Yes, specify (	of Hispanic uban, Mex	Origin? (Sp	pecify Yes or N Rican, etc.)	lo-	14. Race - A Black, W	merican Indian, hite, etc.	
al,	þ	1 ☐ Never Marri 3 ☐ Widowed		ied	1 ∐Yes 2 If Yes, Give Year or Dat								HITE		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Eva once.	olete	15. Decedent's Education (Specify only highest grade completed)					(G	cedent's Usual Oc ve kind of work do o. DO NOT use re	ne during i	most of work	ding	16b.	Kind of Busine	ss/Industry	
d withigiene.	Completed	Elementary/Secon			College (1-4	lor 5+)	FLOE					AG	RICULTU	RE	
be filed ntal Hyg ed othe event,	Be C	17. Father's Name (	(First, Middle,	Last)					18. M	lother's Nam	e (First, Middi	e, Maide	en Surname)		
should band Men s marked umatic	욘	JOHN FRA					1						TE DXU		SKI
id 2 st ith an 27 is n traur		19a. Informant's Na						iling Address (Str							
s 1 and of Health item 27 other t		20a. Method of Disp	position	HUSB			Place of Dis	B HAGY RO position (Name or rematory or other			Date MA		Location - City		
Pages ment of ant: If its any or o		1 ☐ Burial 2 ☐ 4 ☐ Donation			noval from St		-	KE CREMA		03/0	1/2012	STE	VENSVII	LE. MAR	RYLAND
permit. Departr Importa any inji		21. Signature of Fu	neral Service	Licensee	, ,	/		22. Name and Ad ELLOWS,							
= a o		23a. Part 1. Enter the	nel K.	AZ	U/a	Me	.	30 SPEER	ROAL	) CHES	TERTOW	N, M	IARYLANI	21620 Approxim	
Dharidan		shock, or hea	rt failure. List	only one	ause on ea	ch line.							000-11	Interval E Onset an	Between
Physician /Medical		disease or condition resulting in death)		a		r as a conse		LRHOSI	> h	JITH 6	NCEPT	HTU	UPHINAT	730	jears
Examiner		Sequentially list cor	nditions	b	·										
ed sit	Examiner	if any, leading to im cause. Enter Unde Cause (Disease or	mediate rlying	2	Due to (o	r as a conse	quence of):								
be executed cian and urial-transit	xan	that initiated events resulting in death) L		c	Due to (o	r as a conse	quence of):								
te be e ysiciar e buri	- 1			L _{d.} _											
rtifical ng phy as th	Medi	IF FEMALE:													
eath certificate b attending physic for use as the bu	Physician/Medica	23b. Was decedent in the past 12		23c.	1 Live bi	me of pregr th 2 Pet	al death	3 ☐ Ectopic pregr					23d. Date of Month	delivery Day	Year
the de y the s ched f	ysic	1 ☐ Yes 2 5 9 ☐ Unknown	No		9 Unkno	int at time of wn	death	5 ☐ Other (specif	)						
s that ined b e deta	by Pr	Part II. Other signif	icant condition	ons contrib	outing to dea	th but not re	sulting in the	underlying cause	given in P	art I.	23e. Dio	tobacco	o use contribute	to the cause o	of death?
equire een sig ould b	ed b										1 🗆	]Yes	2 No 3	Probably 4	Unknown
law r has be	Completed											opsy	prior	autopsy finding to completion o	gs available of cause of
n: The ficate r, pag											1 □ Yes	-	No 1 🗆		
/siclai s certi directo	o Be	25. Was case referrexaminer? 1 ☐ Yes 2 🛣		Hos	pital: 1 □ In	patient 2	FB/Outpa	ient 3 DOA	Other:		th <i>(Check only</i> ome 5□ Re		6 ☐ Other (5	(necify)	
ng Phy Iter thi	n: To	27. Manner of Deatl			28a. Date of		28b. Time	of 28c.	njury at Vork?	2 Ivaising I i	28d. Describe			респу	
tendir eath. or: A	catic	2 Accident	investig	gation					□Yes	2 □ No					
or At after d Direct I in by	Certification:	4 Homicide	determ		28e. Place o building	f Injury - At I g, etc. <i>(Sp</i> ec	nome, farm, ify)	street, factory, offi	e		28t. Location City or T		and Number or ate)	Rural Route N	umber,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier (Check only	Certifyir	g Physici Examiner	: On the bas	sis of examin	owledge, de ation and/o	eath occurred at the investigation, in r	e time, da	te and place death occu	, and due to the	ne cause e, date a	e(s) and manne	r as stated. due to the cause	e(s)
o the vithin 2 o the omple	Medical	one) 29b. Signature and	title of certifie	, 1	and manne	er stated.		29c. Lic	ense numb	per		29d. E	Date signed (M	onth, Day, Year	)
		> th	uA	M	Un	- m		D	004	158	7		1-29.		
10		30. Name and addre	ess of person	who comp	oleted cause	of death (Ite	m 23a) (Typ	e. Print)			,				
ms		Helen	Nob	21_	122	>0e	erk	oca C	nest	erto	Wn.	MI	216	20	
Sta	te	31. Date filed (Mont	ui, ala ar)	. 1 66	32. Re	trar's Sign	aluie	Town I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma		epartment of F Certificate of D			201	2 08275		
	Dhysisis	-/	Decedent's Name (First, Middle, Last)				2. Date of Death	. No.	3. Time of Death		
	Physicia Medic	al	Marian Peters Cun	ningham			February	z ^{Day} 20, 201:	2 3:20 a M		
	Examin	er	4a. Facility Name (if not institution, give street and number)  349 Elm Street			Location of Death		4c. County of Dea	th cil		
	Funeral		Social Security Number	(In yrs. last birthda	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign		
	Director			5 Yrs	Months Days	Hours Min.	March 10	,1916 Pe	nnsylvania		
	and show lat	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits		
	Maryl 28a-f otifiec	irect	Maryland Cecil		Perryvil	lle			1 🔀 Yes 2 🗆 No		
	th the 3a or t be n	al D	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	ountry?		
	ath wi	Funeral Director	349 Elm Street  11. Marital Status 12. Was Decedent E	ver in U.S. 1	3 Was Decedent of His	21903	cify Ves or No-	U . S	S.A.		
õ	fter de , or fter amine	by	1 ☐ Never Married 2 ☐ Married Armed Forces?	40	3. Was Decedent of His If Yes, specify Cubar		Rican, etc.)	Black, Whit			
5-0036	ours a atural'	eted	3 M Widowed 4 □ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No			1	White		
ر د	be filed within 72 hours after death with the Maryland antal Mygiene. Red other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	ompleted	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5-	(Gi	ecedent's Usual Occupa ive kind of work done d e. DO NOT use retired)	ation uring most of worki		sb. Kind of Business A.Medica			
7	J withi ygiene her th it, the	O	One Year	,	Medical S	Secretary	Pe	erry Point	, Maryland		
yland	ntal Hy red oth	To Be	17. Father's Name (First, Middle, Last)  Howard B. Peters				e (First, Middle, Mai	,			
2	should be fill and Mental is marked of aumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b M	ailing Address (Street a			3. Carroll			
, Mar	nd 2 st salth a n 27 is er trai		Phyllis Cunningham (daugh		Keesey Lar				21903		
ore,	ye 1 ar t of He If iter or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State	cemetery, c	sposition (Name of crematory or other place	9)		c. Location - City or			
baltimor	iit. Pag artmen ortant: njury		4 Donation 5 Other (Specify)  Principio Cemetery 02/25/12 Perryville,  21. Signature of Funeral Service Licensee  Principio Cemetery 02/25/12 Perryville,  22. Name and Address of Facility Lee A. Fatterson & Son Funeral Home,								
е С	permit. Page 1 and 2 should be f Department of Heath and Menta Important if item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Licensee	eral Home, 3-0766	P.A.						
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.		,	1	r respiratory arrest,		Approximate Interval Between		
~P	hysician/ Medical		resulting in death)	voncy	tisease			Onset and Death			
1	Examiner		Due to (or as a consequence on):								
,	p #	nine	cause. Enter Underlying	consequence of):							
	and l-trans	Exan	Cause (Disease or iinjury that initiated events c. Due to (or as a	consequence of):							
20	cate be executed physician and s the burial-transi	edical Examiner	d	. ,							
000	uncare ng ph)	-	IF FEMALE:								
o Ko	arn cerunicate be executed attending physician and for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 ponths? 23c. If yes, outcome of 1 ☐ Live Birth 2	Fetal death	3 Ectopic pregnancy	/		23d, Date of de Month	livery Day Year		
Ď.	y the a	hysic	1  Yes 2 No 4 Pregnant at 9 Unknown	ume or death	5 Other (specify)			Wichter	Day leai		
ָר בּיִּ	gned b	by P	Part II. Other significant conditions contributing to death bu	t not resulting in th	e underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?		
Olds,	equire een si	eted	H3 Pothywidism				1 🗆 Yes	2 □ No 3 □ P	robably 4 🛛 Unknown		
מ מ	e law r e has b ge 2 sh	Completed					24a. Was an autopsy performer	prior to	topsy findings available completion of cause of		
ב וּ	rhysician; me la rthis certificate ha ral director, page?		25. Was case referred to medical		26. Pla	ce of Death (Check	performe 1 Yes 2	No 1 ☐ Yes	2 💆 No		
VIC	njs cer I direc		examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatier	nt 2 ER/Outpat	LOtho			e 6 Other (Spec	ify)		
5	h. After ti	ate:	27. Manner of Death  1 Natural 5 □ Pending  28a. Date of injury (Month, Day,		y work?	'	8d. Describe how i	njury occurred			
	ar deat ector: by the	Certificate:			M 1 ☐ 1	res 2□No	28f. Location (Stree	t and Number or Rui	ral Route Number,		
<u>ב</u>	al Dire		building, etc.	(Specify)			City or Town, S	tate)			
Hoop Hoop	The happing of Artending Frightians. The law requires that the deam cerming thinkin 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use at	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examiner on the basis of examiner. On the basis of examiner on the basis of examiner. On the basis of examiner on the basis of examiner.	amination and/or inv	estigation, in my opinior	n, death occurred at a	the time, date and p	lace, and due to the	cause(s) and manner stated.		
P. of	Vith Com	_	29b. Signatore and title of certifier  Som Gim M 113		29c. License	number Y	29d.	Date signed (Month	n, Day, Year)		
	5		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type		mp 2	1078				
	State	-	31. Date filed (Month, Day, Year) FEB 2 2 2012 32. Registrar	1	1	V .	/ 0		<u>-</u>		
T	Registra		1 18 4 ~ ~ LUIL plener	~ B.	parke						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2\,\tilde{0}\,\,|\,\,2$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Conover 10:12AM Harold Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC g. Birthplace (State or Foreign Country) NJ If Under 1 Year If Under 24 Hrs **Funeral** Social Security Number 6 Sex Age (In yrs. last birthday) 8. Date of Birth Feb 6, 1934 Director 1 Ϊ M 2 🗆 F 153-24-1748 78 iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 229 Baltimore Ave. Apt. 702 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give "natural", 3 XWidowed 4 Divorced Korea white Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) Subway System construction superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bernice May Files Daniel Conover Rural Route Number, City or Town, State, Zip Code) 21555 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura 20600 Oliver Beltz Rd. SE Lisa Paz daughte injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of 1 X Burial 2 Cremation 3 Removal from State 4 Onaxion 5 Other (Specify) 2/28/2012 Patapsco Cemetery MD Finksburg 22. Name and Address of Facility all Home, PA Signature of 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ACUTE Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown Completed . Were autopsy findings available prior to completion of cause of death? autopsy perform the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2/200 ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending s after death.

I Director: Af
d in by the fu 1 Yes Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Mpnth, Day, Year)

Registrar

no

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Registrar's Signature

Podrumar M.D. 12502 Willaubrook Rd. Ste. 300 Cumberland, MD 21502

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

12-01515 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dorothy Ireland Christopher State of Maryland / Department of Health and Mental Hygiene Amended #8, # For State , 19b, TCHD, 2/23/2012 Certificate of Death I.S. Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Medical Examiner** Month Day February 20, 2012 DOROTHY IRELAND CHRISTOPHER 1842 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Easton Talbot **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign MARYLAND Director Months Days Hours 2 X F 220-28-2354 Country) 78 JUNE Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f ahos ther traumatic event, the Medical Examiner must be notified at once. or 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", ar items 32s, 23s, 5 and MARYLAND CAROLINE 1 Yes 2 X No Director PRESTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5150 FRAZIER NECK ROAD 21<u>655</u> UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married Armed Forces 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 MAIL CARRIER U.S. POST OFFICE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) WILLIAM CHARLES IRELAND Be MARJORIE HOLT PENNINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street And 10 or Rural Route Number, City or Town, State, Zip Code) GILBERT EUGENE CHRISTOPHER SON 23625 GILPIN <del>POINT</del> ROAD PRESTON, MD 21655 20a. Method of Disposition filmore, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State or other 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION Donation 5 Other Specify CENTER <u>2/22/2012</u> STEVENSVILLE, nature of Funeral Ser 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON STREET EASTON, MD Part I. Enter the disease, or comple **Physician** the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Approximate Interva /Medical Between Onset and a Multiple Blunt Force Injuries **Ēxaminer** Immediate Cause (Final disease Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23d. Date of delivery 1 Live birth 2 Fetal death past 12 months? 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown ned by the a Part II. Other significant conditions Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available page 2 s autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural Feb 20, 2012 death. 5 Pending 1825 hrs Pedestrian struck by motor vehicle To the Funeral Director: completely filled in by the 1 Yes 2 V No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City (Specify) Major Road / Highway or Town, State) 21062 Dover Bridge Road, Preston, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TLS

30. Name and address of person who com deed vause of death (Item 23a) 2

31. Date filed (Month, Day, Year FFB 23 State Registrar

29b. Signature and title of certifie

Russell Alexander MD

Assistant Medical Examiner 32 Registrar's Signature

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

February 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29^{pay} 201 2^{ear} Men DOZIER-HALL 2:15P M DEBORAH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15801 Phillips Oak Drive Montgomery Spencerville 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Apr 6 1 9 5 6 219 64 2893 1 M 2 1 F Days Hours Washington DC Director 55 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Spencerville Md Montgomery 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 15801 Phillips Oak Drive 20868 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No 1990

If Yes, Give 2012 Black White, etc. 1 ☐ Never Married 2 🖾 Married 72 hours after Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2012 Specify: 3 Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. other than " Elementary/Seconday (0-12) should be filed with and Mental Hygien Social Worker Federal Goverment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eddie L. Dozier Lena Staton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $208\,6\,$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gregory Hall, Husband 15801 Phillip Oak Drive, Spencerville Md 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Alexandria, Va 3/3/2012 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 21. Signature of Pheral Service Licensee 621 Florida Avenue, Wash. DC 2001 NW. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Metastatic Pancreas Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death the 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been sig ge 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy , page performed? Yes 2 X No death? certificate 1 ☐ Yes 2 🖾 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🛛 No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗵 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide М neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a

To the Funeral D

completed filled i Medical 1 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DC19655 March 1 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John L. Marshall, MD 3800 Reservoir Rd, Nw Washington, D.C.

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D29, 2012 Mariastella DiPasquale February 9:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 10005 Frank Tippett Rd. Cheltenham Prince George's ial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-50-5271 Hours **Director** 1 □ M 2 **X X** 82 Yrs 02/04/1930 Ita1_v Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Director 1 Yes 2x X No Maryland | Prince George's Che1tenham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be 20623 Funeral 10005 Frank Tippett Road USA items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ within 72 hours after 1 ☐ Yes 🔭 No Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 3 rd College (1-4 or 5+) In Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ Baldassare DiCaro Giacoma Gallo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalia Grubbs / Daughter 486 Thistle Place Waldorf, Maryland 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature — uneral envice Licenses Gate Heaven Cemetery 3/10/2012 22. Name and Address of Facility George P. Kalas Funeral Home, P. A 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pancreatre Concer Physician/ 2 months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 X No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director; After t  $5 \square$  Pending work?
1 Yes 1 🔀 Natural 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ıÛ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records,

M.D. 8926 Woodyard Rd Suite 101 Clinton, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 6:20 p.m.M February Daugherty Bertha Lee Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours Min Director 104-16-4980 1 □ M 2 🗓 F North Carolina 11/22/1917 Usual Residence of Deced 94 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21585 Peabody Street 20650 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Examiner Armed Forces? 0 1 Never Married 2 Married þ altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 XWidowed 4 ☐ Divorced White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic even မ James Albert Foyles Lvdia Barfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a P.O. Box 329, Port Republic, MD20676 Carroll Daugherty/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cametery, crematory or other place)
Spring Hill
Memory Gardens 1 Burial 2 Cremation 3 Bemoval from State 9 Department of Important: If any injury or 4 ☐ Donation 5 🛛 Other (Specify) Entombment 03/05/2012 | Hebron, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) as a consequence of): Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No 9 Unknown for To the Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af completely filled in hy the form Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

William D. Boyd II, M.D.

MAR 05

31. Date filed (Month, Day, Year)

2) pml

25365 Point Lookout Road, Leonardtown, MD

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

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Maryland 21215-0036	2 should and Me Is mark aumatic	To	19a. Informant's Name/Relationsh	<u>-</u>					and Numb	er or Rural	Route Numb		or Town, State, Z	ip Code)	
	1 and 2 Health Sm 27 I		Gloria McCool/Da	ughter	20h B	1237			st Ka	Da	kton,		_ocation - City or 1	Town State	
Baltimore,	Pages in nent of I ant: If ite		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp			emetery cre	matory or a	ther place	e) ry F			l	ark, DE	own, otato	
Balt	permit. Pages 1 and Department of He Important: If item any injury or other.		21. Signature of Funeral Service L	icensee	UIII						2,2012 es , P.A.				
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200	ne deal the att	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Prec 9 □ Unk	gnant at time of d		Other (sp		y				Month	Day Y	/ear
S. P.	requires that the death certificate be e peen signed by the attending physician hould be detached for use as the burie	oy Ph	Part II. Other significant conditio	ns contributing to o	death but not resu	ulting in the u	ınderlying c	ause give	en in Part I		23e. Did		use contribute to	the cause of de	eath?
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of.	Attending Physician: or death. ector: After this certific by the funeral director,		1 ☐ Yes 2 No  27. Manner of Death	28a. Date	∫Inpatient 2 ☐ e of Injury	ER/Outpatie		28c. Injun	er: 4 □ Ne vat				6 ☐ Other (Specury occurred	oify)	
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shivis	I or Atte after de Directo I in by tf	Certification: To	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Plac build	e of Injury - At ho ding, etc. (Specif	ome, farm, st	reet, factory	, office		21	8f. Location City or To	(Street a wn, Sta	and Number or Ru te)	ıral Route Numi	ber,
180	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C		g Physician: To th Examiner: On the											:)
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	6		30. Name and address of person	who completed cau	use of death (Item	n 23a) (Type,	Print) C	ico,	RGE De G	ISC	WAK	D 3	2/078		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Harry Austin Dolly 39AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Hours Months Days 214-28-6426 **Director** 79 1 X M 2 - F 09/03/1932 West Virginia Usual Residence of Decedent 28a-f show ttal Hygiene. et other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director MD Allegany Cumberland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11208 Creek Road, SE USA 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) should be filed with and Mental Hygien is marked other th Home Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta. Important: If item 27 is marked any injury or ~~ ပ Dolly Belle Delmar Susie Tmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia E. Dolly / Wife 11208 Creek Road, SE, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Glendale Cemetery 03/03/2012 Flintstone, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Adams Family Funeral Home. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atheroschentic Cardioviscular Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Unknown 2 No the 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24 hours after death. Funeral Director: After this certificate has autopsy performed Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasis of one 3 Certifying Nurse Practitioner: To the (Check best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) March 2,2012 36 166

State

Registrar

924 Seton Drive, Cumberland, MD

21502

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Vik Poonai,

31. Date filed (Month, Day, Year)

NAR U 2 2012

Elmer Charles [		, Jr. State 1- For State	e of Maryland / I	Depart		alth ar			Reg. No.		2 0828	
Physici Medical Exami	an/	Registrar  1. Decedent's Name (First, Middle,La  Elmer Char		Jr.				2. Date of Do Month February	eath	Year 012	3. Time of Death 1833 hrs	
		4a. Facility Name (if not institution, gi 712 Oliva Street			Sali	sbury	Location of Dea		V	Vicomico		
Funeral Director				In yrs. last	birthday) If Un Mon Yrs.	ths Day		8. Date of lin. 08/1.		Fore	ign	
daryland 23a-f show aoy 1 at 90cc.	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicom	1		own or Location						10d. Inside City Limits 1 Yes 2 X No	
h the Mary 23a or 28a.	I Director	10e. Street and Number 1108 Kiowa Ave.				ip Code	21801			USA		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked offer thao "natural", or items 23a or 28a-f sho injury or other traumatic evect, the Medical Examiner must be notified at socce.	by Funeral		1 Yes 2 X d If Yes, Give Year or Dates:	No	If Yes, spec	cify Cuba		to Rican, etc.)		White, etc.  Specify: Black		
36 thin 72 hours the "natu edical Exau	Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)		6a. Decedent's Usua during most of w Painter						-	
215-00 be filed wit ntal Hygien rked other	Be	17. Father's Name (First, Middle, Las Elmer Charles D	•				18.Mother's Nai Ada I	me (First, Middle Mae Sher	e, Maiden	Asymptotics    Asymptotics   Asymptotics   Asymptotics		
MD 21 nd 2 should alth and Me m 27 is ma aumatic cy	은	19a. Informant's Name/Relationship ( Elmer Duffy III  20a. Method of Disposition		Look Bi	12834 M	Marbl	estone 1	Or., Woo	odbri	.dge, VA	22192	
limore, Pages 1 arment of He		1 X Burial 2 Cremation 3 4 Donation 5 Other Specific	ce of Disposition (Namatory or other place Pauls U. Lurch Ceme	e) M		/1 /2012	(2012 Paralia MD					
		21. Signature of Funeral Source Licensee  22. Name and Address of Facility Holloway Funeral Home Professional As 501 Snow Hill Rd., Salisbury, MD 2180  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										
Physician /Medical Examiner		failure. List only one cause on e	ach line. Multiple Gunshot  Due to (or as a consequ	Wounds					,		Between Onset and	
	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ									
e executed cian and rial - transit		UNPENDED	AMENDED									
Division of Vital Records, P.O. Box 68760, sa for Atroching Physiciae: The law requires that the death certificate be an Director. After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buri	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	23c. If yes, outcome 1 Live birth 4 Pregnant at tim 9 Unknown		2 Fetal death		Ectopic preg	nancy	230		•	
, P.O. Box ires that the deatl signed by the att	ā	Part ii. Other significant conditions	contributing to death be	ut not resu	liting in the underlyin	ng cause	given in Part I.					
of Vital Records, P.O. B iog Physiciae: The law requires that the de After this certificate has been signed by the uneral director, page 2 should be detached in	Completed					00.51	10 4 (0)	per 1 <b>✓</b> Yes	is an opsy formed?	prior to death?	completion of cause of	
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Division of Vital Is the Hospital or Attending Physiciae: hin 4 hours after death. the Funeral Director: After this certifingletely filled in by the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigal	28a. Date of Injury FOUND: Day, Year) ion Feb 20, 2012	)   F	Bb. Time of Injury OUND: 825 hrs		ry at Work? Yes 2 ✔ No	28d. Describe Subject sh		iry occurred		
E 6 5 E	Certification:	3 Suicide 6 Could not determine	be 28e. Place of Injury		e, farm, street, factor obile	ry, office t	building, etc.	or Town	State)		ural Route Number, City	
To the Hos within 24 h To the Fuc	Medical	one) 2 Medical Examine	ian: To the best of my kin: On the basis of examinand manner stated.	nowledge, nation and/	or investigation, in m	ny opinior	, death occurred	nd due to the ca	te and pla	ce, and due to t	ne cause(s)	
	2	29b. Signature and title of certifier	allan			9c. Licens O.C.	e number M.E.					
93			ant Medical Examir	ner 90	0 W. Baltimore	Street	Baltimore, I	MD 21223				
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	Examin	er	4a. Facility Name (if not institution, give				4b. City, Town, or		of Death			c. County o		
-	Funcial		Atlantic General 5. Social Security Number 6. Se		In vrs lasi	t birthday)	Berli If Under 1 Year	n Tif Under	24 Hrs.	8. Date of Bir		Worce		ace (State or Foreign
	Funeral Director			XM2□F	82	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)		Count	ry)
	D W	L	Usual Residence of Decedent  10a, State  10b, County		10- 01- 1	T	- 1			Aug. 3	30,	1929		yland
	ryland I-f sh ied al	ctoi			,	Town or Loc	ation						10	od. Inside City Limits  1 ☐ Yes 2 🔀 No
	or 28a notif	Dire	MD Worces  10e. Street and Number	ter	Be	erlin	10f, Zip Code				10g. Citizen of What C			
	with th	Funeral Director	510 Flower Street				21811					USA	iai ooaiii	
	eath v	Fune	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. W	/as Decedent of H Yes, specify Cuba	ispanic Or	lgin? (Spec	ify Yes or No-		14. Race		
215-0036	ified within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 🔄 Yes 2 🗌 No If Yes, Give Year or Dates.	° 1951 <b>-</b> 1956	_	Yes, specify Cuba						, White, e Blac	
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Mary	should be fil and Mental 7 is marked raumatic ev		19a. Informant's Name/Relationship (Ty		- 1	19b. Mailing	g Address (Street						ite, Zip Ci	ode)
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o e	t of Heal If item 2 or other		20a. Method of Disposition 1	Removal from State	20b. Pla cen	ce of Dispos netery, crem	sition (Name of atory or other plac	e)	D	ate	20c. l	Location - C	City or Tov	vn, State
baltimore,	t. Pag rtmen rtant: rjury		4 ☐ Donation 5 ☐ Other (Specif	)	St.		JMC Cemet							
ga	permit. Page 1.8 Department of H Important: If ite any injury or ot		21. Sign turn of Funeral Service Licens	a. Sal	low		Name and Address 11ey Mem		. 00	alisbur œl - 1				oad 21801
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the cause of each line.	ne death.	Do not enter	r the mode of dyin	g, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between
4	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due t (or as a c	umb	n1'a	7							Onset and Death
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09/99	ertifica ding p		IF FEMALE:	23c. If yes, outcome of	prognano	n.,								
POX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal o	death 3	Ectopic pregnand Other (specify)	у				23d. Date Mont		ry Day Year
	hat the ed by detac	y Ph	Part II. Other significant conditions co	ntributing to death but	not result	ting in the ur	nderlying cause giv	en in Part	I.	23e. Did to	obacco	use contrib	ute to the	cause of death?
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0	ding F h. After funer	ate	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, )		8b. Time of injury	28c. Injun work M 1	yat .? Yes 2.⊑		8d. Describe t	now inju	ry occurred		
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_	100		29b. Signature and title of certifier  M + 1				29c. License	number	-0		29d. Da	ate signed (	Month, D 7 ol 2	ay, Year)
	575		30. Name and address of person who c	ompleted cause of door	th (Item 2)	3a) (Type P	int)	,710			2/	~~		
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H	Stat Registra	e ar	31. Date filed (Month, Day, Year) FEB 29	2012 32. Regis rar's	Signatur	· A. x	29c. Licenson DCOE  h Way D  parks							

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State of Maryland / Department of Health and Mental Hygiene 2 1 1 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 18:22 PM 2012 Lisa Ann McMillan March Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Ctr Harford Bel Birthplace (State or Foreign Country) If Under 1 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 204-56-5477 Director 49 1 🗆 M 2 🔀 F 01/01/1963 <u>Maryland</u> Usual Residence of Deceden f show at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location rector notified -28a-f 1 Yes 2 No MD Harford <u>Darlington</u> Ö 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1821 Robinson Mill Road 21034 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Maryland 21215-00 is marked other than "natu aumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Okie Hammons Edith Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a mportant: If item 27 Don McMillan (Husband) 1821 Robinson Mill Rd., <u>Darlington, MD</u> injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Tabernacle Cemet. 103/08/2012 Whiteford, MD of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complica shock, or heart failure. List only one Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or a la jonsequence of) for use as the burial-transi Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death funeral director, page 2 should be detached ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an or Attending Physician: The law has autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manne eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation completely filled in by the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Ne Supp Day, Year) 31. Date filed (Month, State 1 6 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended # 1- State Of Washington Amended # 1- Registrar 4b, FH, 2/28/12, r1s Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 FEBRUARY 11:45A M MARGARET A. DELEAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oxford EASTON TALBOT 202 3RD STREET

5. Social Security Number 6. 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 DXF Months Min. (Month, Day, Year) 87 Davs 1924 WASHINGTON DC Director 579-22-2584 HINE 21 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Director 1 Yes 2 No GAINSVILLE VIRGINIA PRINCE WILLIAM 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6947 WALNUT HILL DRIVE USA 20155-3015 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 2 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 X No Maryland 21215-0036 WHITE 1 Yes 2 X No Specify: If Yes, Give Specify: 3 - Widowed 4 - Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 3 REGISTERED NURSE US GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ ALICE MOULD WILLIAM MOULD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is <u>JOHN F. DELEAN / HUSBAND</u> 6947 WALNUT HILL DRIVE GAINSVILLE, VA 20155-3015 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEARE' CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/28/2012 STEVENSVILLE, MD 22. Name and Address of Facility
'ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON STREET EASTON, MD 21601 21. Signature of Funeral Service Licensee MERCERON OHN P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Physician/ edema Medical Due to (or as a consequence of) Examiner diabetic Years and entensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine physician and s the burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending pl e asn. IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 Yes 2 9 Unknown detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ge e 2 XNo 3 Probably 4 Unknown Records, 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other RESIDENCE 2 NNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 🖾 Natural 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Va February 057740 27 mentre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. WASHINGTON ST, EASTON, MD-21601 VAIDYANATHAN LAKSHMI 31. Date filed (Month Day Yes) 8 2012 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			1 - State Registrar	•	C	ertificate of l	Death		Reg. No.	UIZ	002	00
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ы	Medie		Shirley L. Diaman	toni				02	27	2012	2001	М
. 84	Examir		4a. Facility Name (if not institution, give street an		- //	4b. City, Town, o	r Location of Deat	h	4c. Cd	ounty of Death		
Transfel .	<u> </u>		PeninsulA REGIONAL		MALU		544150414			HIOOM	100	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday	) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi		9. Birth Cour	place (State or For	reign
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	ow st	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or I	ocation				<u> </u>	I 0d. Inside City Li	mits
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	r dea iner		Arm	Decedent Ever in U	J.S. 13	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ilispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	14.	Race - Americ Black, White,		
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	If Ye	Yes 2 XNo s, Give or Dates.		1 Yes 2 X No	Specify:		Spe	ecify: wh	ite	
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Maryland	should be filed within and Mental Hygiene. is marked other tha raumatic event, the N		19a. Informant's Name/Relationship (Type, Print,		19b. Ma	iling Address (Street	and Number or Ru	ral Route Numb	er, City or To	vn, State, Zip (	Dode)	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Tony S. Diamanton:	i / husk	and I	L0153 Qu	eens Ci	rcle,	0cean	City	, MD 21	842
re,	of He fitem		20a. Method of Disposition	20b.	Place of Dis	position (Name of ematory or other pla	1	Date	i	tion - City or To		
Baltimore,			1 ☐ Burial 2 ☐XCremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)			State Cr		9/2012	   Mill	shoro	. DE	
alti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	1		22. Name and Addre						
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	Medical		disease or condition resulting in death)	JOYDN OU		rerg	17 13 Ca	70				
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Вох	leath e atte id for	sicis	1 Ves 2 No	Pregnant at time of		Other (specify)	Су			Month	Day Year	
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Or	w rec s bee	Completed by						24a. Was	an 2	4b. Were auto	psy findings avails mpletion of cause	able
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of	g Ph er thi			Date of injury (Month, Day, Year)	28b. Time injury		v at	28d. Describe			/	
nc	ttendin death. stor: Aft y the fur	ical	1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(IVIOITITI, Day, Tear)	injury		Yes 2 No					
Division of Vital Records,	er de ecto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At I building, etc. (Speci	nome, farm, s	treet, factory, office				umber or Rura	Route Number,	
Ο̈́	talor saft			bulluling, etc. (Speci	19)			City or To	vn, State)			
	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tetely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the									etatad
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	only one) 3 Certifying Nurse Practit	ioner: To the best of	f my knowledg	e, death occurred at	the time, date and p	place, and due to	the cause(s) a	and manner as	stated.	Stateu.
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			I have newsend			D4	6536		02/	27/2	0/2	
	. 1		30. Name and address of person who completed	cause of death (Ite	m 23a) (Type	Dutant)		40				
D	H 6			100 E. C	Carroll	st Sal	is bury	MO 3	2/801			
	Sta	te	31. Date filed (Month, Day, Year) FEB 2 9 2012	32. Pigistrar's Sign	ature	st Sal						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma		ertificate of D			ene eg. No. 20	2 08289
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give street and number)	EKT	4b. City, Town, or	Leasting of Dooth	FEBRUARY	15 20 4c. County of D	
	Examin	er	LORIEN @ RIVERSIDE		4b. City, lowii, or	BELCAMP			RFORD
-68	Funeral		4 🗆 14 A 🔯 E	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9.	Birthplace (State or Foreign Country)
	Director		243-32-5556 The Parameter of Decedent	85 Yrs.	Wionina Dayo	Tiours Willi.	OCT 8	1926 NC	ORTH CAROLINA
	and show	or		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla 28a-f stified	Director	MARYLAND HARFORD		HAVRE DE	E GRACE			1 X Yes 2 □ No
	h the		10e. Street and Number		10f. Zip Code		10	ng. Citizen of What	
	ith wit ms 2: must	Funeral	1414 BAYVIEW DRIVE  11. Marital Status 12. Was Decedent Ev	ov in 116 140		21078	esit Vas er No		ED <b>ST</b> ATES
9	er dez or ite miner	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 N	0	Was Decedent of His If Yes, specify Cuban		Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
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72	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		Elementary/Seconday (0-12) College (1-4 or 5+	1	DO NOT use retired) MINISTRATI	VE ASSIS	STANT	FEDER!	AL GOVERNMENT
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Baltimore, Maryland 21215-0036	1 and 2 should be f Health and Men Item 27 is marke other traumatic	3	19a. Informant's Name/Relationship (Type, Print)  JOHN R. RICHARDSON / FRIEND		ling Address (Street ai			•	Zip Code) ARYLAND 21078
ē,	of Heal of Heal fitem :		20a. Method of Disposition	20b. Place of Disp	osition (Name of			20c. Location - City	
<u>E</u>	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ematory or other place IEMORIAL GI		1/12	BEL AIR,	MARYLAND
Salt	permit. Page 1 Department of Important: If it any injury or c		21. Signature of Funeral Service Licensee	2	22. Name and Address	s of Facility LI	SA SCOTT	FUNERAL	HOME, P.A.
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~.P	hysician/		shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition	Fai	Cure	, such as cardiac	or respiratory arres	ι,	Approximate Interval Between Onset and Death
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189	death certifical te attending phed for use as the	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d. Date of	delivery
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<b>⋝</b>	Physic this c	: To	1  Yes 2 No Hospital: 1 Inpatier  27. Manney of Death 28a. Date of injury	t 2 ER/Outpatie		4 Mursing H	ome 5 Resider		pecify)
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Division of Vital Records,	io the nospital of Attending Prysician: Io the hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	/ - At home, farm, si (Specify)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
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i	vithii To th comp	_	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Mo	onth. Day, Year)
			* ALCMO		1/20	066		(14	12
_	2		30. Name and address of person who completed cause of do	ath (Item 23a) (Type,		oust.	Havn	e de	Erail
	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	1	- 1 / (	11-61/10		21078
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ Joseph Duard Evans Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western MD Regional Medical Center Allegany Cumberland 8. Date of Birth (Month, Day, Year) June 25, 1921 . Social Security Number 7. Age (In vrs. last birthday Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Min. Hours Director 90 176-12-1110 1 **X** M 2 □ F 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Frostburg 1 ☐ Yes 2 🛣 No Maryland Allegany or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16615 National Highway SW 23aFuneral U.S.A. 21532items ? death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces: If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. o. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural", 3 X Widowed 4 ☐ Divorced Year or Dates. WWII traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ATK Carpenter and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Delia Alice Richmond Joseph A. Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Gary Evans 16607 Oceanview Lane SW Maryland 21532-Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State **Eckhart Cemetery** March 05, 2012 Eckhan Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or at a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) executed the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FFMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by & ailuse 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed Yes 2 No 1 🗌 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 风No Other: ၉ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of De th 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Μ 1 Yes 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification 7+ who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Year Physician/ Month 2:40 PM Elsworth Roloff 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 H/s. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months (Month, Day, Year) 214-22-3057 **Director** 1 🗶 M 2 🗆 F 88 10-25-1923 Maryland Usual Residence of Deced nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Harpoon Road 21811 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

Yes 2 No Black, White, etc 1 Never Married 2 Married þ 1943 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced 1946 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th 9 Owner/Operator Motorcycle Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown မ Roloff Ear1 Ione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 s.
Department of Health a.
Important: If item 27 is George Brac - Friend 24 Harpoon Road, Ocean Pines, Maryland 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 2-24-2012 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 Park 1. Enter the disease, or cor shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ne cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC ULMONAR OBSTRUCTIUR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events at initiated events.) Due to (or as a consequence of) Exami certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1 No Other: TOther (Specify) HOSPIE 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Injury at 28d. Describe how injury occurred 💆 Natural 5  $\square$  Pending work? 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Bup 180 33 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 26 per med cert G925 3716/12 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **EVESON** Physician/ ROBERT GORDON Month Day Year MARCH 2012 1 . 30P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3268 CAPTAIN DEMENT DRIVE CHARLES WALDORF Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours **Director** 498-26-3085 XXM 2 F MAR.16,1929 TENNESSEE 82 Yrs Usual Residence of Decedent a or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA ORANGE LOCUST GROVE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? the Medical Examiner must be Funeral 23a 22508 342 YORKTOWN BLVD. U. S. A. items? within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces 1 Yes 2 No If Yes, Give Year or Dates. 30 o by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: "natural", 3 X Widowed 4 Divorced Completed YEARS 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) AIR NATIONAL GUARD MASTER SERGEANT other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is reany injury or other 2 ROBERT ARTHUR EVESON GERTRUDE DELPHINE GIESELMANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON HUMPHRIES/DAUGHTER 342 YORKTOWN BLVD., LOCUST GROVE, VA 22508 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MARCH 14,2012 1x Burial 2 Cremation 3 Removal from State TRINITY MEM. GRDNS. 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. wure of Funeral Service 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ ancel disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Strestdence 6X Other (Specify 27. Manner of Deal 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) State 1 6 2012 MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 25, 20^{rear}2 2:10 АМ Ann Ex1ey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Sunrise Assisted Living 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Birthpia Country) Ohio **Funeral** Month, Day, Hours Min. 1 □ M 2 😿 F 290-28-3622 79 Director Feb. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Frederick Frederick Maryland 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a death with United States 21702 990 Waterford Drive ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify:White 3 ₩ Widowed 4 □ Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Helen Elizabeth Boehm Albert Bernard Little 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10925 Rawley Rd., New Market, MD 21774 Richard Riley/Brother-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 28 Department of Himportant: If ite any injury or ot Feb. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 2012 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funeral Service Licensee 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Fig Monset and Death LUNG Physician/ CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 🔲 Yes 2 🔀 No Month Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **N**No 1 Tes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, e Hospital or Attending PP n 24 hours after death.
e Funeral Director: After the leted filled in by the funeral Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pendina injury 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signal

Registrar
DHMH 17 Rev 7/2009

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State

dress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Day, Year)

10062223

1967J DHUE PROPERLY, MP 21702

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

an al	Lecia Evelun Geo	aRS		March	1 2012	16007
er	4a. Facility Name (If not institution, give street and number)	4b. City, To	vn, or Location of Deat	h 4	c. County of Death	1
	5. Social Security Number 6. Sex 7. Age In yrs. last bir	rthday) If Under 1	ear If Under 24 Hrs	8. Date of Birth	9. Birth	nplace (State or Foreign
	217-30-8054 1 M 2X F 80	Yrs. Months D	ays Hours Min.	(Month, Day, Yea. 11/21/1931	r)   Cot	untry) <b>'LAND</b>
	Usual Residence of Decedent			1==, ==, ==, ==		
'n	10a. State 10b. County 10c. City, Tow	n or Location				10d. Inside City Limits 1 ☐ Yes 2 ■ Yo
ectc		ERTOWN		10- (	Distrement Milhort Co.	
ā	10e. Street and Number	10f. Zip Co			Citizen of What Cou	
eral	217 CENTRAL DRIVE  11. Marital Status 12. Was Decedent Ever in U.S.	21620	t of Hispanic Origin? (S		TED STAT	
Fun	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	If Yes, specify	Cuban, Mexican, Puer	to Rican, etc.)	Black, White	
by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □ Yes 2 🖸	No Specify:		Specify: WHI	TE
Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual C	occupation done during most of wo		Kind of Business/I	ndustry
g E	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use	etired)			
ပ္ပ	17. Father's Name (First, Middle, Last)	OMEMAKER	18 Mother's Nar	me (First, Middle, Maide	N HOME	
은	JAMES FRANKLIN WILLIAMS  19a. Informant's Name/Relationship (Type. Print) 19b	Mailing Address (S		LLIAN USIL' ural Route Number, City		(in Code)
		,		STERTOWN, N		
	20a. Method of Disposition 20b. Place o	of Disposition (Name ery, crematory or other	of i		Location - City or T	
	1 Burial 2 Cremation 3 Removal from State	ER CEMETEI		06/2012 СНІ	STERTOWN	, MARYLAND
	21. Signature of Funeral Service Licensee	22. Name and	Address of Facility	N & NEWNAM		
	* Lord of Spefelie			STERTOWN, N		
	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of	f dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	400malic	arrolle	000		Onset and Death
	resulting in death)  Due to (or as a consequence	Δ . Δ				
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min	cause. Enter Underlying Cause (Disease or injury	ELZMOT	60			
Exa	that initiated events resulting in death) Last C. Due to (or as a consequence	of):	<u> </u>			
sician/Medical Examiner	d. IDDM					
Ned	IF FEMALE:					
an//	23b. Was decedent pregnant  1 Live birth 2 Fetal death	h 3 🗆 Ectopic preg	nancy	3	23d. Date of deli Month	very Day Year
	1 Yes AND 4 Pregnant at time of death 9 Unknown	5 ☐ Other (spec	ify)		MOTH	Day leal
Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cau	se given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
d by	Eponioneen Boursey Pertie	Timb		1 ☐ Yes	2	obably 42 Unknown
lete	Read Edwar			24a, Was an	24h Were au	topsy findings available
ďως	The sales Tanger			autopsy performed?	prior to death?	completion of cause of
Be C	25. Was case referred to medical	<u>-</u>	26. Place of De	1 ☐ Yes 2 ≥ 1 ath (Check only one)	lo   1 ⊔ Yes	2 No
	examiner? 1 ☐ Yes 2 No Hospital: ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA	Other:	Home 5 ☐ Residence	6 ☐ Other (Spec	oify)
L:uc	27. Manner of Death ↑ Natural 5 Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)	Time of 28c	Injury at Work?	28d. Describe how inj	ury occurred	
cati	2 Accident investigation	М	1 ☐ Yes 2 ☐ No			
ırtifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, o	fice	28f. Location (Street and City or Town, Sta	and Number or Ru ite)	ıral Route Number,
ပ္	29a. Certifier Certifying Physician: To the best of my knowledg	e death occurred at	the time, date and place	se, and due to the cause	(s) and manner as	stated
Medical Certification: To	((Check only one)  2 Medical Examiner: On the basis of examination at and manner stated.					
Me	29b. Signature and title of certifer	29c. L	icense number	29d. E	Date signed (Month	h, Day, Year)
	(GIMA)	V	X) 0456	, පිළ	3/2/	208
	30. Name and address that in who completed cause of death (Item 23a)	(Type, Print)	200,000	- 01.000	T 78	D 51650
	CONTRACTOR VIGOR	(4)	MUUUN >	1. GIVOILES	10000 1,	0 01000

Reg. No. 2

State

Registrar

31. Date filed (Month, Day, Year)

MAR - 5 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02 22y 2012 10:18A Raymond John Gilboyne Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ceci1 North East 80 Sunset Manor Drive Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Davs 69 **Director** 152-32-1909 1 🔀 M 2 🗆 F 7/18/1942 NJ Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ms 23a or 28a-f shomust be notified at 10a. State **Funeral Director** 1 🗌 Yes 2 🔀 No North East 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 21901 80 Sunset Manor Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married X Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify. Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4 or 5+) Airlines Airline Pilot Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Mary Conaway Raymond J. Gilboyne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 Sunset Manor Drive, North East, MD 21901 Margaret Gilboyne - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or of once. 1 Burial 2 X Cremation 3 Removal from State 02/27/2012 4 Donation 5 Other (Specify) Rising Sun, MD T. Foard Funeral Home, 4 Li Dunasco...
Signature of Funeral Service Licensee R.T.Foard Funeral Home, PA (. 259 E. Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final MERKEL CELL CARCINOMA Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 1 \( \text{Alesidence} \) 6 \( \text{Other} \) Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

completely f 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) MD D0062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN
2533 AUGUSTINE HORMAN HWY, SVITE A, CHESAPEAKE CITY, MD 21915

Registrar DHMH 17 Rev 06-2011

State

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08296 State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Month Physician/ Year Virginia Carter Gray 2012 Feb 2000 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Salisbury Wicomico 620 Wellington Circle Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 214-68-5838 **Director** 1 □ M 2 😿 F July 23,1940 VA 71 Usual Residence of Dece 28a-f shov 10a. State must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral with 1 items 23a USA 620 Wellington Circle 21801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Black, White, etc.

African ò þ 1 Never Married 2 Married 1 Yes 27 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", Specify 3 X Widowed 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homecare 6th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Mildred E. Harmon Samuel P. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other 621 Wellington Circle, Salisbury, MD 21801 Virginia Roberts/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 3/2/2012 4 Donation 5 Other (Specify) Green Acres Mem Park : Salisbury, MD 21. Signature Freral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD also 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the cause Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a onsequence of) **Examiner** Sequentially list conditions Dub to (or as a consequence bi). ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examir The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 35 IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? jo Day Month Veal Pregnant at time of death
Unknown signed by the at d be detached for 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to complete of cause of 24a. Was an page 2 has autopsy perform death? Z No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 1 Yes 2 No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 esidence 6 Other (Specify) funeral 27. Manner of Death 4 hours after death.

uneral Director: After thely filled in by the funera 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 U Yes 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certif 29d. Date signed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Registrar

State

· 333 Mill Street, Howerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Borbara Nocley-Blucher

1 6 2012

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ iraini nces 6:10A eb Medical acility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Cane -0 hester 6 Under 1 Year 8. Date of Birth (Month, Day, If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes Give 3 ₩idowed 4 □ Divorced Completed Year or Dates lack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 2 other traumatic 19a. Informant's Name/Relationship (Type, 19b Mailing Address (Street and Number of 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury or 1 Burial 2 Cremation 3 Removal from State eterans emetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any 61 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death END STAGE DEMENTIA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No 2 1 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🍱 No completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No injury Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D69234 2012

Registrar DHMH 17 Rev 7/2009

State

JEEVAN

31. Date filed (Month, Day, Year)

NAR OS

51

BYRN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERRABOLO

503

2. Registrar's Signature

03,05,

MD

CAMBRIDGE

21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner 8. Date of Birth (Month, Day, Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 MM 2 F Hours Min **Director** Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 nan "natural", e Medical Exan 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced BIOCK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Saac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Green 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)
M. a Shore Crematical by 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of acility Henry Funeral Home, P.A washington Str Cam 510 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine or as a consequence of Due to and -trans that initiated events resulting in death) Last (or as a consequence of): ng physician a e as the burial∺ Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending p thed for use as t IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Í. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy this certificate 2 No Yes 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifler 29c License number 167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1165. bnth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08300 State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4 - 1 2 ay Minnie Alice Holder 7:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville PGThomas More 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 - 24 - 1908 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Min. 1 □ M 2 □X€ Hours Country) irginia 579-68-5848 Director 103 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director D.C. Washington 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Usa 20019 108 Kenilworth Ave.N.E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces 2 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Childcare Governess Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H is marked ot ပ Petty William Petty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 3367 Alden Pl, N.E., Washington, D.C. 20011 Gladys Yette- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington National2/29/12 Arlington, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Service Lige 411 Kennedy St NW Washington, DC 20011 23a. Part 1. Enter the diselse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failed. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Arterioscherotic Cardiovasulan Disease Physician/ ears disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or se a consequence of it any, leach g to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 e attending p I for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Perebral infarction Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛍 Unknown Completed ATTIAL & brillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \omega \) No Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Matural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 001852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queens buy &d Hyattsville MD 20781 DEVORE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hillian 1:07 PM 2012 Chruain Medical lity Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death Birthplace (State or Foreign Country) vrs. last birthday 8 Mate of Birth **Funeral** (Month, Day, Year) 244-92-5963 1 🛂 M 2 🗆 F 57 Director May 21,1954 North Carolina 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 XYes 2 No DC N/A Washington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ms 23a or must be n Funeral 1374 Tewkesbury Place, NW 20012 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ŏ 1 Never Married 2 Married by Maryland 21215-0036 within 72 hours after **Black** 1 ☐ Yes 2 X No Specify. 'natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. I **other than** " life. DO NOT use retired) Elementary/Secondary (0-12) the Director of Finance Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ Jasper Hilliard Virginia Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trau L. Vanessa Gibbs/Wife 1374 Tewkesbury Place, NW Washington, DC 20012 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

03/12/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Pat/1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or a consequence o **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ped : the Unknown g Unknown P.O. I been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy berformed Director: After this certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural Acciden 5 Pending 1 🗌 Yes 2 🗌 No hours after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pietely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 600 North

Wolfe Street

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 William February 10:29 am George Harper, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Germany 1 🖾 M 2 🗆 F Months Days Hours Oct. 23 214-70-4494 53 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 X Never Married 2 Married Specify:White 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Elfriede Rahstorfer Harper, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elfriede Harper/Mother 13503 Keating Street, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Feb₂₀₁₂₉, 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA . Signature of Funeral Service Let Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause peach line. Immediate Cause (Final Onset and Death disease or condition resulting in death) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): 23d. Date of delivery 3 

Ectopic pregnancy Year

Physician/ Medical Examine

Physician/

Medical

10a. State

MD

**Examiner** 

Funeral

**Director** 

or 28a-f show

23a

items

, or

"natural",

Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant. If item 27 is marked other than ury or other traumatic event, the Me

permit. Page Department of Important: If any injury or

the Medical

Examiner must be notified at

Director

Funeral

þ

Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ER

Examine To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bung-transit Completed by Physician/Medical

Be မ

Certificate:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

after death

within 24 hours a

Division of Vital Records, P.O.

resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Yes 9 Unknown

25. Was case referred to examiner?

Manner of Death

2 X No

29b. Signature and title of certifier

1 
Yes

1 Natural

2 Accident
3 Suicide
4 Homicide

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5

4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death

5 Other (specify)

Month Dav

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes

24a Was an performed 24b. Were autopsy findings available prior to completion of cause of death?

									1 ∐ Yes 2 No	1 ☐ Yes 2 ☐ No
to medical 26. Place of Death (Check only one)										
No	Hos	spital: 1 [	Inpatient 2	X	ER/Outpatient	з 🗆	DOA Other: 4	☐ Nursing H	lome 5 Residence 6 C	Other (Specify)
5 Pending Investigation			e of injury onth, Day, Year)		28b. Time of injury	М	28c. Injury at work? 1  Yes	2 🗆 No	28d. Describe how injury occ	urred
6 Could not be determined			ce of Injury - At ding, etc. (Spe		me, farm, street )	t, facto	ory, office		28f. Location (Street and Nur City or Town, State)	nber or Rural Route Number,

📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check nly (ne)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction or To the basis of my in only dogs and procured at the time date and place, and one to the cause(c) and manner as stated. 29c. License number

29d. Date signed (Month, Day, Year)

e and address of person wi

31. Date filed (Month, Day, Yea) 32. Registra

State Registrar

Please Type or Print in Black Indelible Ink. Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 29,2012 Florence Castle Hartle 4:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Williamsport 10909 Stuart Drive Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2X F 219-36-3689 97 July 7,1914 MarvTand **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2XXNo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 USA 10909 Stuart Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. <u>\$</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Jane Sterling Roth Albert Castle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9610 Park Street Manassass, VA 20110 Lucinda Karalow - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Spe Hagerstown Crematory 03-01-2012 Hagerstown, Maryland 21. Signature of Fineral Sept 22. Name and Address of Facility Osborne Funeral Home, P.A. Williamsport, MD 21795 425 S. Conococheague St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Month Day Year Pregnant at time of death the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 8 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and place, and due to the cause(s) and manner stated.

Gertifying Number Practionary: To the basis of my knowledge death occurred at the time, date and place, and place, and manner as etated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nam and address of person who complete cruse of death (Item 23a) (Type, Print) ASSIT my WW SED Registrar's Signature 2 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Karthini Year Hamich 0818AM Firh 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE SHADY GROVE ADVENTIST HISPITAL MONTGOMERY 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Director 1 🗆 M 2 🎜 F LANKA 28a-f show 10c. City, Town or Location Examiner must be notified at Director GERMAN 1 Yes 2 No MONTGOMERY 23a or 2 10g. Citizen of What Country? 208 Funeral SRI LANKA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces "natural", or i Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ASIAN 3 Widowed 4 □ Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) HOME HOME OWN MAKER is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည BURAH SURAYA BURAH KITCHIL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19a. Informant's Name/Relationship (Type, Print) RAZEEN MANNAN SON-IN-LAW 20508 GOLF COURSE DR. GERMANTOWN item 27 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of P Important: If ite Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 01 FREDERICK, 12 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER. 21. Signature of Funeral Service License e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final My oi ardeal Infaction Physician/ MINUTES disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown ed by the a 1 ☐ Yes 2 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 Wo 1 Inpatient 2 FR/Outpatient 3 IDOA ည 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, upletely filled in by determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Certer Proper Mockville Kella IPUL 9901 Date filed (Month, Day, Year, MAR U 22012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carol 2012 Hairston Medical March 7:15 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Hospital Ft. Washington Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 455-58**-**1900 **Director** 1 🗆 M 2**X X** F 75 04/03/1936 Texas Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1740 Rhodesia Avenue 20744 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, vvas Decedent Ever Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: Black Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wru. ∼tal Hygiene. ∽er than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Rep. should be filed with and Mental Hygien 7 is marked other th 2 years Cosmetics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 01a Richard Benton Flossie Beatrice Parker permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Hariston - Husband 1740 Rhodesia Avenue Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 03/08/2012 Cheltenham, Maryland 4 Donation 5 Other (Specify) Maryland Vet. Cem. 22. Name and Address of Facility George P. Kalas Funeral Home PA uneral Service Li 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, ardiac disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ertension Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial Innerial inector, page 2 should be detached for use as the burnal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an performed **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 K ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) erimeter Rd, Andrews AFB, MD 1050 IM Tran 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH Year 8:49AM Lottie Shannon Heeger 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Washington Boonsboro Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) North Carolina Hours 237-16-4798 **Director** 91 Aug Usual Residence of Decedent mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland nardment of Health and Mental Hygiene.

oorlant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 141 South Main Street 21713 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married E: | | | EEGER LOTITE Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Hairdresser Cosmetology Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nathan Rheu1 Wolfe Daisy Grantham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda S. Kehl/daughter Schoolhouse Court Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important; If it
any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 03-03-2012 Frederick, Maryland 21. Signature of Fundal Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA Call 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Eyer the disease, or complication at cayled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause in each line.

Immediat: ause (Final a MR 15210 SCL BROTIC CARDIO VASCULAR Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): DISEASE YRS Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Id be detached for 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERICHERAC VASCULAR DUSERSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed NTREALIBIDEMIN DIMBETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has CO LO VARY ARTERY DUSTIO DEMENTIL performed? this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MMC12, 2012 D (80 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DATTA STREET VASANT 340 HAGERSTOWN, MARYLAND 21740 301-739-7100 31. Date filed (Month, Day, egistrar's Signatur State 2012

Registrar

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryland		ificate of E		i Wentarry	Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Middle, Last Khalik Jerard Be					2. Date of De Month	Day	2012	3. Time of Death 1314 M
	Medic Examin		4a. Facility Name (if not institution, give s	street and number)		4b. City, Town, or		Februa		ty of Death	1 1314
_			University of Mar	,		Baltim If Under 1 Year	ore If Under 24 Hi	70 Lo D		I a Bill	
	Funeral Director		5. Social Security Number 6, Se 1 [ Usual Residence of Decedent	X 7. Age (In yrs. las	Yrs.	Months Days	Hours Min 3C	n. (Month, Da	8,2012	9. Birthin Coun Mary	place (State or Foreign htry) Land
	and show	tor	10a. State 10b. County		, Town or Loca					1	10d. Inside City Limits
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	items	Fune		Was Decedent Ever in U.S. Armed Forces?	. 13. Wa		-	Specify Yes or No- erto Rican, etc.)	14. Ra	ace - Americ ack, White,	
9030	ırs after o ıral", or I Examir	ed by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates.	1	☐ Yes 2 X No				fy: Bla	
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land	l be filed lental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Gerard Bell				18. Mother's N Heathe	ame (First, Middle, er McInti	, Maiden Surnai <b>r</b> e	me)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	.0	19a. Informant's Name/Relationship (Ty) Gerard Bell-fath		19b. Mailing 44 Fa	Address (Street a	nd Number or F Ave. H	Rural Route Number lagerstow	er, City or Town n, MD 2	State, Zip 0 2 <b>174</b> 0	Code)
nore,	age 1 and ent of Hez it: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State ce	ace of Disposi emetery, crema	tory or other plac	ory 3-2	Date 2-2012	20c. Location		
Baltır	permit. P Departme Importar any injur once,	Ų	21. Signature of Funeral Service License		22.	Name and Addres	s of Facility	ouglas A . North	. Fiery	Fune	ral Home
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P.O.	hat the led by t detach	by Phy	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the und	derlying cause giv	en in Part I.	23e. Did 1	tobacco use co	ntribute to th	he cause of death?
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o uc	Attending Physician: Ther death. ector: After this certificat by the funeral director, p.	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work		28d. Describe	how injury occu	irrea	
Division of Vital Records,	l or Atte after dea Director	Certificate	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location ( City or To		ber or Rural	l Route Number,
	To the Hospital or Attending Physiciam: within 24 hours after death within 24 hours after death.  To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Examin	ician: To the best of my knowle ner: On the basis of examination	and/or investig	gation, in my opinio	n, death occurre	d at the time, date	and place, and o	due to the car	use(s) and manner stated.
	<b>To the</b> within 2	Ž	only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	e Practitioner: To the best of m	y knowledge, d	death occurred at the 29c. License		d place, and due to	the cause(s) and 29d. Date sign		
			KMasalL	Roberkson	MO	1023	30485	88	3-3	- 20	12
J	W-1		30. Name and address of person who c	ompleted cause of death (Item	1 11		mp	2120	1		
	Sta		31. Date filed (Month, Day, Year) 5 2	012 32. Registrar's Signatu		and	1		•		
	Registra	ar	1.55444	And the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t	14.	A W.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Physician/ 10:44 M obruary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Days Hours Min 219-36-3613 1 X M 2 🗆 F 70 April 16 1941 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 10828 Wyncote Drive 21740 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Social Services Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Lee Hull Christine Alberta Shore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Marie Hull - Wife 10828 Wyncote Drive, Hagerstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Greenlawn Mem. Park 3/2/2012 Williamsport, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral Home Vole 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Medical Examiner burial-transi and attending physician Division of Vital Records, P.O. Box 68760 the as signed by peen has

**Funeral** 

Director

show

28a-f

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23a

notified at

must be

ral", or items ? Examiner mus death

"natural"

f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical.

Department of Health Important: If item 27 any injury or other to

Ph. sician/

Page 1 and 2 should be filed within 72 hours after

21215-0036

Baltimore, Maryland

Physician/Medical by Completed Be မ Certificate:

Medical

25. Was case referred to medical 27. Manner of Death

examiner?

Natural

2 Accident
3 Suicide

29a. Certifier

(Check

2 No

5 Pending

Investigation 6 Could not be

determined

600120102

Director: After this certificate filled in by the funeral director, Hospital or Attending death. after 24 hours

TW - 12

within 2

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Hospita

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 PER/Outpatient 3 IDOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

Hec/ Sh Sollies

1 Yes 2 No

26. Place of Death (Check only one)

Other:

28c. Injury at

29d. Date signed (Month. Day, Year,

28f. Location (Street and Number or Rural Route Number,

1 Yes

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Yes 2 No

Hagpyteun MODIT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 egistrar's Signatur

Brock Love

08309

			1 - State Registrar	0.0.00	ar y rai re	Cer	tificate of L	Death	A, 101 111	orrical rij	Reg. N	0.			
	Dhysisis	/	1. Decedent's Name (First, Middle	, Last)						2. Date of De	ath			3. Time of Death	_
	Physicia Medic		Coletta	Mary	Hal:	iscak				Month <b>Februa</b>	ry 2	$\frac{27}{27}$ , $20$	12	4:56 p.m.	
1.44	Examin	ner	4a. Facility Name (if not institution				4b. City, Town, o	r Location o	f Death			c. County of			
10 Marchan			St. Mary's Nurs  5. Social Security Number		/l l	A for facility of the A	Leonard  If Under 1 Year		24 Ura		_	t. Man			_
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			Usual Residence of Decedent	TEM ZOALF		Yrs.				01/29/	192	4 N	ew	York	
	sho	ţō	10a. State 10b. County		10c. City,	Town or Loc	cation						1	Od. Inside City Limits	
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	h the Sa or be n	a D	10e. Street and Number				10f. Zip Code				10g. C	itizen of Wha	t Coun	try?	-
	th wit ms 23	Funeral	23106 Marble Wa					619			Uni	ted St	ate	S	
	r deal	F	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig an, Mexican,	jin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		14. Race - A			
Baltimore, Maryland 21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2x Marr 3 ☐ Widowed 4 ☐ Divorced	If You Cive	Vo	1	☐ Yes 2X No	Specify:				Cannifu	Whi		
9-0	hours natur lical I	Completed		nt's Education		16a. Deced	ent's Usual Occup	ation			16b. k	Kind of Busin			-
215	in 72 e. nan "i	m d	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-4 or 5-	+)	(Give k life. DC	ind of work done of NOT use retired)	during most	of working	7	1		000/11/0	,	
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nd	ital Hyged oth event,	To Be	17. Father's Name (First, Middle, L					18. Mothe	r's Name (	First, Middle,	Maiden	Surname)			
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<b>B</b> a	permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trau once.		Edward N. Bri	2	м000				111 11	nsfield 1, Leon	l Fu nard	neral town,	Hon MD	e, P.A. 20650	
г			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that caused nly one cause on each line.	the death.	Do not ente	r the mode of dyin	g, such as c	ardiac or r	espiratory ari	rest,			Approximate Interval Between	
d	hysician/		Immediate Cause (Final disease or condition	_a_Demo	other									Onset and Death	
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8760	icate g phy: as the	Medical		G											_
39			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			Ectopic pregnanc				1	23d. Date of	delive	У	
Вох	death	Physician/	in the past 12 months? 1  Yes 2 No	4 Pregnant at			Other (specify)	У				Month	-	Day Year	
P.O.	t the	Phy	9 Unknown							1					_
σ.	es that the dea signed by the a l be detached f	þ	Part II. Other significant conditio	ns contributing to death bu	t not result	ting in the ur	iderlying cause giv	en in Part I.						cause of death?	
rds	equire een s hould	eted								1 📙 '	Yes 2	VZ No 3 L	J Prob	ably 4 🗌 Unknown	
Records,	The law rate has b	Completed								24a. Was a	SV /	prior	to con	sy findings available pletion of cause of	
ž	i: The									1 Yes	rmed?	deat		? □ No	_
ita	sician: certifica irector,	m	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:			Othe	ace of Death				_			
<u></u>	Phys r this eral di	일	27. Manger of Death	1 Inpatier 28a. Date of injury		R/Outpatient	3 DOA	4 M Nur		5 Resid			oecify)		_
n	nding th. : After e fune	cate	Natural 5 Pending 2 Accident Investig	g (Month, Day,	Year)	injury	work			a. Describe II	ow injur	y occurred			
Sic	Atter	Certificate:	3 Suicide 6 Could r	not be 28e. Place of Injury	y - At home	e, farm, stre				f. Location (S	treet an	d Number or	Rural F	Route Number,	-
Division of Vital	al or		4 Li Fiornioide	building, etc.	(Specify)					City or Tow	n, State,	)			
_	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Luneral Director. After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check 2 L Medical Ex	Physician: To the best of m xaminer: On the basis of exa	amination a	nd/or investi	gation, in my opinio	n, death occ	urred at the	e time, date ai	nd place	, and due to t	he caus	e(s) and manner stated	1.
	o the		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner: To the	best of my	knowledge,	death occurred at the 29c. License		and place			e(s) and mann te signed (Mo			_
	F S F Ö		> Kin onlood	tom			DO	- 0	00		9	1001.	2	ay, rour,	
			30. Name and address of person w	who completed cause of dea	ath (Item 2:	3a) (Type: Pr		, , ,			-	- 1   1			_
5	)enil		2007 Tide	sla stou	my .	Dr.	Suite IA	1 A	-nnc	ziloga	, (	no!	2/1	101	
	Stat Registra	•	31. Date filed (Month, Day, Year)  MAR 08	2012 37. Registrar	's Signatur	for	KN			•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ emary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Battimore niversity of Manyland Medizal Center If Under 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** 1 🗆 M 2 🔀 F 68-55 AUG 17, 1956 MARYLAND ms 23a or 28a-f show must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MARYLAND HARFORD BELCAMP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4203 CHAPEL GATE PLACE 21017 UNITED STATES or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. BLACK Specify: 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CERTIFIED NURSING ASSISTANT NURSING HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ၉ DANIEL PEACO SOPHIA HARDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauonce. TINISHA HARRIS / DAUGHTER 4203 CHAPEL GATE PLACE, BELCAMP, MARYLAND 21017 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/27/12 ABERDEEN, MARYLAND MT. CALVARY UAME CEM. 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, 21. Signature of Funeral Service Licensee 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 cott. Co 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxic Respiratory Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-trar and Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy erformed? Be ( 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Yes ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 V Natural 5 Pending 2 Accident 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) Battimore UD 21291 Greene St

DHMH 17 Rev 06-2011

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Рм NANCY LEE HITCHENS /Medical Feb 2012 8:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 178 Manor Circle Elkton Cecil If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 221-26-9449 Hours Min. 69 Months Days 4 27 7 1 9 4 2 Wilmington, Director Usual Residence of Decedent 10d. Inside City Limits show 10a, State 10b. County 10c. City. Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examinar must be not infinited at Director 1 ☐ Yes 2 ☐ No MD Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 178 Manor Circle 21921 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes → No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Customer Service Representative 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilhelmina Robinson Joseph Raymond Pierson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code)
178 Manor Circle, Elkton, MD 21921 19a. Informant's Name/Relationship (Type. Print) Dawn Sutcliffe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State United Crematory Services 2/10/2012 Newark, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad St., Middletown, DE 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XNo 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending To the Hosping, ... within 24 hours after death.

To the Funeral Director; Aft 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier/ 29d. Date signed (Mopth, Day, Year) D0062190

State Registrar SHAHNAWAZ KHAN

Svite A, chesaplake city, MD 21915.

MD

Herman Hwy

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hugustine

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar  1. Decedent's Name	e (First, Middle	e, Last)				Cel	liiica	le oi L			2. Date of De	Reg. N eath			3. Time of D	Death
Physicia Medic		GENEVIE		NONA	HANS								Month 02	2	26 2	012	7:00	<b>A</b> . ^M
Examin	er	4a. Facility Name (if  1 Baltin		. 0			7			y, Town, or Cumber		of Death		4	lc. County	of Death		
Funeral		5. Social Security No		6. Sex	, <b>Ар</b> с		yrs. la	ast birthday)		ler 1 Year	If Under	24 Hrs. Min.	8. Date of Bit				place (State or	Foreign
Director		217-10-52 Usual Residence of			VIZ LANGE		96	Yrs.					09/16/	6/1915   <u>Maryland</u>				
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permir Depar Impon any in		year	A De	Tes)	chu	(a)			202	Green	ne St	reet	hurch E	erla	ind,	MD :	21502	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 € 9 ☐ Unknown		23c.		Birth 2 [ nant at tim	Feta	I death 3	Ectopi Other		У					ate of deliventh	very Day Ye	ear
that th	by Ph	Part II. Other signif	icant condition	ons contri	buting to d	leath but n	ot resu	ulting in the u	nderlyin	g cause give	en in Part	I.	23e. Did	tobacco	use cont	ribute to	the cause of dea	ath?
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To the vithin To the comp	2	29b. Signature and		7					$\overline{}$	9c. License	number			29d. D	ate signe	d (Month,	Day, Year)	
4		30, Name and addre		//		/SC			trint\	V.	108	44			02	127	12012 mp 21	
nds			100	SE T	- 60	VER	IA	23a) (Type, P	MD	91	2 St	ron	PLIVE C	um	BM	MUD,	MPZI	205
Stat Registra		31. Date filed Wonth	B 29	2012	34. R	legistrar's	Signat	ure foot	March St.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 16:55 PM Ethel Heath Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninaula Regional Medical Cente Nicomico Salisbun Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under Director 212-40-7607 1**X** M 2 □ F 69 3-6-1942 MDiral", or items 23a or 28a-f show Examiner must be notified at 10a. State 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Somerset Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32360 Flower Hill Church Road 21822 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes X No Specify. "natural", Completed 3 Widowed 4 Divorced SpedBolack Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 9 Domestic Worker ₩.F. Allen Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ray Jones Edith Travers and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 1 and 2 sof Health Martha Christopher/Daughter 32360 Flower Hill Ch Rd, Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, XBurial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 2-25-2012 Flower Hill Cem Signature LL ral Service Licensee 917 W. Isabella St. Bennie and Address of Earlity 136 Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death h sician/ which disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death
Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform 1 Yes 2 No Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 21/2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury ours after death.

Neral Director: Aft

filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, MA 2.20.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE SOYB, SAUSBURY, MD 21801 ZARTEN AMMED 106 MILTORD 31. Date filed (Month, Registrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Month Physician/ Hicks LOIL. 1155 PM E Jernon Medical 4a. Facilify Name (if not institution, give street and number) 4c. County of Death Anne Arendel 4b. City, Town, or Location of Death Examiner 1142 Medgar Evers Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours **№** M 2 🗆 F Director 217-58-2082 60 6 1951 May Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral IISA 21401 2122 Willie Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after conspanient of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumair. þ 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify: Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4 or 5+) 10th Equipment Operator Waste Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Hicks Sr. Ida Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Colbert (Sister) Victor Parkway Annapolis, Md. 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
pe St. Mark
Y. Church 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/25/12 Edgewater, Md 22. Name and Address of Facility
M. Reese & Sons Mortuary,
922 Forest Dr. Annapolis, 21. Signature of Funeral Service Licensee m. Reese & 922 Forest P.A. Md. 21401 Bears 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ oronary disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in the position, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0066086 dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 116 Defene Highway, Suite 400, Annepolis, MD 21401 Grustkowski, MD Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar

			State     Registrar			Cer	tificate of L	Death		Reg. No.	112	08315
	Physicia Medic		1. Decedent's Name (First, Middle, La Annie Harol	*					2. Date of De Month によりい	Day	Year 2012	3. Time of Death 4.304 M
L.	Examin		4a. Facility Name (if not institution, give 7400 HARRISON LAN	E			4b. City, Town, o	IILLS			CE GEO	
	Funeral Director		5. Social Security Number  203–22–8704  Usual Residence of Decedent		e (In yrs. las 86	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours IV	Hrs. 8. Date of Bir (Month, Da	ıy, Year)	Countr	ace (State or Foreign ry) SYLVANIA
21215-0036 within 72 hours after death with the Maryland	of Health and Merital Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	10a. State 10b. County PENNSYLVANIA ALLEGH	ENY	, ,	Town or Loc					10	od. Inside City Limits
th the	3a or		10e. Street and Number				10f. Zip Code			10g. Citizen of		
ath wi	ems 2 r mus	Funeral	715 MERCER STREET  11. Marital Status	12. Was Decedent B	ver in U.S.	13. V	1521 Vas Decedent of H	lispanic Origin?	(Specify Yes or No-	UNITED 14. Rac	STATE ce - America	
36 after de	l", or it camine	þ	1 Never Married 2 Married	Armed Forces? 1  Yes 2 X If Yes, Give	No		Yes, specify Cuba		uerto Rican, etc.)		ck, White, et  BLAC	
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Baltimore, Maryland permit. Page 1 and 2 should be filed	vlental arked o	2	UNKNOWN						E WILLIAM			
Maryla should be	rauma		19a. Informant's Name/Relationship (						Rural Route Numbe	-		
re, N	r Healt item 2 other 1		20a. Method of Disposition	AUGHTER	20b. Pla	ace of Dispo	sition (Name of		TEMPLE HI	20c. Location		
Page 1	U - 1		1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Speci				natory or other place ORIAL CEME			WALDORF	-	
3alti	Department Important: I any injury or once.		21. Signature of Funeral Service Cen	tu Jul		7 ²²	Name and Addre	ss of Eacility UNERAL	HOME, P.A			
	0 0		23a. Part 1. Enter the disease, or com	plications that caused	the death.							LAND 20640 Approximate
~ Ph	sician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line	aunc	er						Interval Between Onset and Death
	Medical aminer		resulting in death)	a. Due to (or as a	a conseque	ence of):						
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68760 ertificate b	g physi as the l	/Medical		d								
× 68	tending or use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth			Ectopic pregnanc	су			ate of deliver	
<b>B0</b>	the at ched fo	Physiciar	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (specify) _			Mo	onth E	Day Year
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed	been signed by the attending physician and should be detached for use as the burial-transit	by Ph	Part II. Other significant conditions	contributing to death b	ut not resul	lting in the u	nderlying cause giv	ven in Part I.	23e. Díd t	obacco use cont	ribute to the	e cause of death?
ds,	en sign	ted k							1 🗆	Yes 2 No	3 Proba	ably 4 🗌 Unknown
SCOT	has be je 2 sh	Completed							24a. Was	psy	Were autops prior to com death?	sy findings available pletion of cause of
<b>E</b>	s certificate has t director, page 2 s		25. Was case referred to medical				26 PI	lace of Death (C	1 Yes		1  Yes 2	? □ No
Vita	nis cer Il direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 🗌 Inpatie	ent 2 🗆 E	R/Outpatien	t 3 DOA Oth	er.	ng Home 5 Resi	dence 6 🗆 Oth	er (Specify)	
n of	n. After tl funera	ate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of injui (Month, Day		28b. Time of injury	28c. Injur work M 1 🗆	yat ⟨?  Yes 2. □No		now injury occurr	ed	
Sio	ector; ector; by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Inju		ne, farm, stre		res 2 🗆 No	28f. Location (	Street and Numb	er or Rural F	Route Number,
Div	ral Dir lled in			building, etc	. (Specify)				City or Tov	vn, State)		
Hosp	within 24 hours after death.  To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Exam	rsician: To the best of niner: On the basis of eace se Practitioner: To the	xamination a	and/or invest	igation, in my opinio	on, death occurr	red at the time, date a	and place, and du	e to the caus	se(s) and manner stated.
To the	To the	2	29b. Signature and title of certifier  MSRAYAPA		Door or my	r Kilowioogo,	29c. License	e number		29d. Date signe	d (Month, De	
	2							0057			7/12	
6	JU.		30. Name and address of person who	completed cause of de M .D . 28	eath (Item 2	23a) (Type, P	n AV S	203	Ba Homo	mp mo	212	-09
	Stat	e	31. Date filed (Month, Day, Year) FEB 2 9 2012	32. Registra								
	Registra 17 Rev 06-2		- 25 4 2 2012	penson	B.	Back	<u></u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08316 State of Maryland / Department of Health and Mental Hygiene 4014 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alice ISEN 2012 5:40 P M February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Montgomery Hospice Rockville 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 163-34-8040 May 17, 1942 1 🗆 M 2 🕶 F Director Pennsylvania 69 Usual Residence of Decede an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Ithaca 1 Yes 2 No Tompkins New York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 14850 37 Horizon Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. b 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Specify: 3X☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the Education Professor  $5\pm$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Eva (unknown)** ပ Saul Eisen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health item 27 7508 N.W. 44th Place, Gainesville, FL 32606 Amir Erez, Personal Representative 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 X Burial 2 Cremation 3 X Removal from State 03/04/12 4 Donation 5 Other (Specify) Upper Darby, PA Har Jehuda Cemetery Trompohingsky: Helmew Funeral Home 21. Signature of Juneral Service Licensee 20012 254 Carroll St., NW, Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Intracranial Hemorrhage Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). and The law requires that the death certificate be executed Due to (or as a consequence of) attending physician I for use as the buria /Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Physician/ 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown 9 Unknown detach by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No Hospice 2 4 Nursing Home 5 Residence 6 Nother (Specify, 1 Inpatient 2 ER/Outpatient 3 DQA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1🗶 Natural 5 Pending o 24 hours after death.

e Funeral Director: After the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

To the Fune

reompletely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month. Day, Year) 0 R 143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20855 Debrah Miller, CRNP, 6001 Muncaster Mill Road, Rockville, MD

Registrar
DHMH 17 Rev 06-2011

State

0 1 2012

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 SARAH VIRGINIA ISAACS **FEBRUARY** 16:39 PM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL OF CECIL COUNTY CECIL ELKTON 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Countr(CECILTON MARYLAND 8. Date of Birth **Funeral** (Month, Day, PRTL 9 1 □ M 2 💢 F Months Days Hours Min. Director 87 <u>219-14-1049</u> PRIL Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XX No MARYLAND CECII NORTH EAST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 513W.OLD PHILADELPHIA ROAD UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💥 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 21215-0036 "natural". 1 ☐ Yes 2 🔀 No Specify: WHITE Specify. 3 XWidowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
MARY FORD ELMER MANLOVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY JANE JOHNSON / DAUGHTER 513W.OLD PHILADELPHIA ROAD, NORTH EAST, MARYLAND21901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State FEBRUÄRY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NOR CEMETERY CEMETORY OF CHEET CLACK
METHODIST CEMETERY 9, 2012 NORTH EAST, MARYLAND 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Enteroco Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year signed by the aid be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Conknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed' certificate Yes 2 Yes the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖳 No ျ 1 Sunpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at Natural (Month, Day, Year) 5 Pending 1 Yes 2 No __ Accident after death Director: / Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State

29b. Signature and title o

and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Clifton Jeffries 26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours **Director** 240-72-4094 **X**□ M 2 □ F 66 1945 6 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 425 37th PL SE 20019 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Force by 1 Never Married 2 X Married 2**X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16h. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d 2 should be filed with alth and Mental Hygien 27 is marked other th Laborer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Jeffries Donnie Ausby 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other terms <u>Charlie Jeffri</u>es- Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 3/3/2012 Resurrection 5 Other (Specify) Signature 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. MydCI-dial Immediate Cause (Final (MKSsive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): death certificate be executed and I-trans that initiated events physician ar resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 L 9 Unknown the 9 Unknown P.0. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Records, cate has been sig page 2 should b Completed 24a. Was an this certificate 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: Hospital or Attending 24 hours after death. Natural 5 Pending hours after death.

neral Director: After filled in by the fur Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a 29a. Certifier 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hour To the Fune completely fi only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8814 Shadow Lake Way Springfield VA 22153 20c. Location - City or Town, State Clinton, MD 22. Name and Address of Facility D.L. McLaughlin Fun. Home 2518 Pennsylvania Ave, SE Washington DC Approximate Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Yes 2 WN 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 8212711 ORIGINAL

 $^{3.\,\text{Time of Death}}_{05\,:\,53}\,P_{_M}$ 

9. Birthplace (State or Foreign

10d. Inside City Limits

Yes 2 No

2012

N.C.

14. Race - American Indian

Black

Black, White, etc.

Specify:

State Registrar 31. Date filed (Month, Day, Year

MAR 0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 120 PM Ethel Irene Jamison February 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Director 219-12-1547 1 M 2 X F 86 Maryland Mar 19, 1925 Usual Residence of Decedent show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 X No Maryland Washington Boonsboro 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 18708 Lappans Road U.S.A 21713 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 0 þ 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 'natural", Completed 3 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ္ Harry David Jamison Bertha Mae Burgan and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 it Deana M. Chambers/granddaughter 18708 Lappans Road Boosnboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) View Cemetery 03-03-3012 Sharpsburg, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD nter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death Ph_sician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perforr death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: မ 1 Tes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 28d. Describe how injury occurred eral Director: After filled in by the funer 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurs To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 12 Physician/ Month 03 Day CATHERINE A JACKSON 02 1350 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death OF MARYLAND MEDICAL CENTER BALTIMORE 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** -36-Hours Min. Director 1 🗆 M 2 🖫 F 72 or items 23a or 28a-f shov 10b. County at 10a. State 10c. City, Town or Location Inside City Limits Director the Medical Examiner must be notified 1 Yes 2 No een Thne rasonvil 10e. Street and Numb 10g. Citizen of What Country? 10f. Zip Code Funeral 216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 'natural", Completed 3 Widowed 4 Divorced ac 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ton and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru + Route Number, Cit or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Obert 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Robinson Cemetery 4 Donation 5 Other (Specify) 101 22. Name and Address of Facility
Henry Funeral Home Signature of Funeral Service Licenses enry Funeral to 21613 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ACUTE MORTIC PISSECTION - TYPE A Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month jo Month Pregnant at time of death be detached Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No Certificate: To 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 5 Pending 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. оmpletely 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatureland title of certifi 29d. Date signed (Month, Day, Year)

State Registrar MIHAE

31. Date filed (Month, Day, Year)

S: GREENE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

2. Registrar's Signature

SHIN-DIEP

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BALTIMORE, MD

ST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Of Maryland / Department of Health and Mental Hygiene 2 | 2

Registrar Opples Are Legible.

Certificate of Dooth dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ mes 11034 M Medical Macility Name (if not institution, give street and number) **Examiner** 4c. County of Death N/A more 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 214-46-1668 Hours **Director** 1 □ M 2**X** F 65 Dec 16 1946 Maryland 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Tes 2 X No 10e. Street and Number r items 23a or ner must be n ö 10f. Zip Code 10a. Citizen of What Country? Funeral 803 Good Harbor Rd. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian er than "natural", or iter the Medical Examiner Black, White, etc. 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Nutrition Site Manager Community Action Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Agency 10thother traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Turner Louise Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or when Charles James (Husband) 803 Good Harbor Rd. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 2-29-12 Crownsville, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Winame Reeseof & cilitSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HUTTI-MGAN SYSTEM FAILUKE Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** PERITONITI Sequentially list conditions, Examiner Due to for as a consequence of, if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events -tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this funeral Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No injury filled in by the Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the desired physician of the desire 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CES-000 FEBRUARY ZZ, 2012 30. Name and address of person who completed cause of death (Item 28a) (Type, Print 31. Date filed (Month State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / De State of Maryland / De Registrar	partment of Health and Mental Hygiene 2012 08322 15/2012dhb ertificate of Death Reg. No.
ı	Physicia Medic		Decedent's Name (First, Middle, Last)     ALBERT RAYMOND KATOSKI	2. Date of Death Month March 4, Day 2012  3. Time of Death 5:40 A M
مرسم	Examin	er	4a. Facility Name (if not institution, give street and number) Wilson Health Care Center	4b. City, Town, or Location of Death  Gaithersburg  4c. County of Death  Montgomery
	Funeral Director		5. Social Security Number 220–44–1495 6. Sex 1 M 2 $\square$ F 89 Yrs	Months Days Hours Min (Month Day Year)
	aryland a-f show fied at	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Montgomery  Gaith	o walto wa
	ith the Ma 3a or 28a it be notii		10e. Street and Number	10f. Zip Code 10g. Citizen of What Country? 20877 United States
(0	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  12. Was Decedent Ever in U.S. 1  Armed Forces?  1 ☒ Yes 2 □ No	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
9-0036	hours afte natural", lical Exar	leted b		1 ☐ Yes 2 No Specify: Specify: White  cedent's Usual Occupation 16b. Kind of Business Industry
Maryland 21215-0036	within 72 giene. er than "i the Med	<b>Completed</b>	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  5+  Bra	ve kind of work done during most of working DO NOT use retired)  nch Chief  Agency
/land	d be filed Mental Hy, arked oth	To Be	17. Father's Name (First, Middle, Last) Alexander Katoski	18. Mother's Name (First, Middle, Maiden Surname) Frances Konwinski
, Man	and 2 should Health and Me em 27 is marl ther traumati	73	19a. Informant's Name/Relationship (Type, Print)  Jean Katoski (Spouse)  12b. M.	alling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Hutton Street Gaithersburg, MD 20877
Baltimore,	- 5 <b>= 2</b>		1 X Burial 2 Cremation 3 Removal from State cemetery, c	position (Name of rematory or other place)  on National  DetaUkn  20c. Location - City or Town, State  Alexandria, VA
Balt	permit. Page Department Important: II any injury or	13	21. Signature of Funeral Service Licensee (M01116)	22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877
	Physician/	7 10	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)  Due t: (or as a consequence of:	Artem Diserre
	d de de de de de de de de de de de de de	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	. I A Marie R
09	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tensity	dical Ex	resulting in death) Last  Due to (or as a consequence of):  d.	CERTIFICATION APPROVED BY MEDICAL EXAMINET
687	n certificat ending ph	യ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 □ Live Birth 2 □ Fetal death (	
O. Box	the death or the by the atter	Physician/M	1   Yes 2   No 9   Unknown	Other (specify) Month Day Year
J.	law requires that the las been signed by the 2 Should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
Vital Records,	he law rec ite has bec age 2 sho	Completed	Gastero intestina F	24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No
Vital	is certifica director, p		25. Was case referred to medical examiner?  1 X Yes 2 No Hospital:  1 Inpatient 2 ER/Outpat	26. Place of Death (Check only one)
Division of	ending Ph sath. or: After th ne funeral	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)  28b. Time injury	of 28c. Injury at 28d. Describe how injury occurred
DIVISI	tal or Atturs after de al Directo led in by the		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 and 1 and 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invonly one) 3 Certifying Nurse Practioner to the best of my knowledge	h occured at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	<b>₽</b> № <b>₽</b> 000		29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) 3/5/20/2
1=	5+1		SATED EISAYTHO 6110	Malelular D. Rockville, MD 20850
	Stat Registra	e	31. Date filed (Month, Day, Year)  NAR 0 6 2012	well.

## Physicia Medic Examin Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

		Plea	ase Type or							-		-	jible.		
	For State		State o	of Maryla	nd / Depa	artmer <i>rtificat</i> (			and N	/lental Hy	gier	ne 2 (	112	08	323
	Registrar  1. Decedent's Name	e (First, Middle	e, Last)		Cei	uncau	e OI L	<i>Jeain</i>		2. Date of De	Reg.	No.		3. Time o	of Dooth
n/ al	Agne	5	Keese							Month O		Day	Year	111	M M
er	4a. Facility Name (if	not institution	, give street and num		-	4b. City,	Town, or	Location	of Death	, 00.	1	4c. County	6	1	
	Anne Arı 5. Social Security Nu		Medical Co			1611		apol:			$\perp$	An		runde1	
	229-24-		6. Sex 1 □ M 2 🗓 F		. last birthday)	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Yea	·	Cou	Birthplace (State or Foreign Country)	
	Usual Residence o			91	Yrs.					July 1	5,	1920	V	/irgini	.a
ctor	10a. State	10b. County		10c. C	City, Town or Lo	cation								10d. Inside C	
Dire	Maryland  10e. Street and Num		e Arundel		I	Edgew			-						s 2 No
ral	300 Wilr		ace			10f. Zip		1037			10g.	Citizen of \	What Co	•	
Completed by Funeral Director	11. Marital Status		12. Was Dece	dent Ever in U	J.S. 13. V	Was Deced			igin? (Spe	ecify Yes or No- Rican, etc.)				ican Indian,	
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To Be	17. Father's Name (F			-				18. Moth	er's Name	e (First, Middle,	Maide	n Surname	<del>)</del> )		
Ĕ	<del>"</del>		r Francis			-			C	arrie I	Fran	ncis			
	19a. Informant's Na Lydia Do		hip <i>(Type, Print)</i> (Daught	er)						l Route Numbe				-	
	20a. Method of Disp	osition		20b.	Place of Dispo			ice,		water,				Town, State	
	1 ੌ Burial 2 ☐ 4 ☐ Donation		3 Removal from	State	t. Mark	natory or o	ther place	erv					,	Mary1	and
	21. Signature of Fun														arra -
_	Show	ash	tatters	n. 50	É	erry	ville	e, Ma	iry1a	Son Fund 219	03-	-0766	ome,	P.A.	
	shock, or hear	t failure. List o	complications that conly one cause on ea	aused the dea ch line.	ath. Do not ente	er the mode	e of dying	, such as	cardiac o	r respiratory an	rest,			Approximation	tween
	Immediate Cause (F disease or condition resulting in death)		_ a	wyto	whe	alu	ulc	wc	Yes	n			- 1	Onset and	Death
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Ž	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outo									001 0-4	e et delle		107
icia	in the past 12 m	nonths?	4 ☐ Pregr	nant at time of	tal death 3 death 5			<u> </u>				Moi	e of deliventh	•	Year
Physician/Medica	9 Unknown		9 Unkn												
	Part II. Other signific	cant conditio	ns contributing to de	eath but not re	sulting in the u	nderlying c	ause give	n in Part	1.					the cause of d	
Completed by									-	1 🗆	Yes	2 ∐ No	3 ∐ Pro	obably 4	Ońknown
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lo Re	examiner?	No	Hospital:	npatient 2	ER/Outpatien	t 3 🗆 DO	Other		th (Check	me 5 Resid	lanca	e 🗆 Otha	r (Cassif	ia)	
	27. Manner of Death	5 Pendin	28a. Date o		28b. Time of injury		Bc. Injury work?	at		28d. Describe h				<i>y)</i>	
	2 Accident 3 Suicide	Investig	gation			М	1 🗆 ነ	es 2 🗌	No						
5	4 Homicide	determi	ined 28e. Place	of Injury - At h g, etc. <i>(Specii</i>	ome, farm, stre y)	et, factory,	office		2	28f. Location (S City or Tow			r or Rura	I Route Numb	oer,
edical Certificate:	29a, Certifier 1	Certifying	Physician: To the be	est of my knov	vledge, death o	ccurred at	the time.	date and	place an	d due to the ca	uleo(e)	and mann	ar ac eta	ted.	1.0
Med	(Check 2 L	Medical E:	xaminer: On the basi Nurse Practitioner:	s of examination	on and/or investi	igation, in m	ny opinior	<ul> <li>death or</li> </ul>	courred at	the time date a	nd plac	e and due	to the co	ulee(e) and ma	nner stated.
— r		tle of certifier	Mark			29c.	License	number	O 6			ate signed		bay, Year)	
		MIL		~			DI	کہ ہ	16			2/1	0/	12	
	30 Name and address	of person w	vho completed cause	of death (Iter	n 23a) (Type Pi	calf	Yaev	4.	An	NOTE O	lis	, MJ	ם כ	1401	
	31. Date filed (Month,	, Day, Year)	32. Re	gistrar's Signa	ature	)	(	J'_	, -, -	P		1//			
		FFRZ	S ZUTZ L	Backers.	1 9.	Marie									

State Registra

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				artment of Health and Mer <i>rtificate of Death</i>	ntai Hygier Reg. i		000 60 7
	Dhusis		Decedent's Name (First, Middle, Last)		Date of Death		3. Time of Death
	Physici /Medi		Brigitte C. Kleppinger		Month 2 19	2012	9:30 p ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		52	201 Dykes Road, Apt 1C	Salisbury	L	Vicomico	
44	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs. 8.   Months Days Hours Min.	Date of Birth (Month, Day, Yea	9. Birthpla Country	ce (State or Foreign
L	Director		10 1 28 0 1 1 1 1 1 2		Month, Day, Yea 2 – 31 – 19	939 Germa	iny
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		100	d. Inside City Limits
	Many f sh	ō	MD Wiscoming Calishan				1 ☐ Yes 2 ☑ No
	288 7001	Director	MD Wicomico Salisbur  10e. Street and Number	10f. Zip Code	10a. 6	Citizen of What Countr	
	3a o		201 Dykes Road, Apt 1C	21804	US		, .
	death ms 2	Funerai		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica		14. Race - Americar	
9	or Ite	Ē	↑ Never Married 2 Married ↑ 1 Yes 2 XNo		ın, etc.)	Black, White, et	
8	ours	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		SpecifyWhite	2
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23a or 28a-f show int, Ira Mickles Exac. il arritust be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Indu	stry
12	within ne. hen	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		G -	16 5	_ a
	lled v tygie ther t		12 Home	emaker		lf-Employ	rea
anc	ntal h	Be		18. Mother's Name (Fil	rst, Middle, Maidi	en Sumame)	
Ž	should ind Men s marke umatic	ဥ	Unk Roeder  19a. Informant's Name/Relationship (Type, Print)  19b. Mailir	Unk			21004
Maryland	0 0 0			ng Address (Street and Number or Rural Ro Marley Manor Dr,			
ē,	of Health Itam 27 other tr			sition (Name of matory or other place C		Location - City or Town	
altimore,	permit. Pages Department of I Important: If Its any injury or of		· Committee of Charles and Charles			ver, DE	,
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ä	Per Per Per Per Per Per Per Per Per Per		Lanced of Fi	ineral Home Salis	hurv	MD 21801	
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			A	pproximate
÷	Physician		Immediate Cause (Final disease or condition	7			nterval Between Inset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of):	<u>U</u>			
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	ק ק	Examiner	if any, leading to immediate cause. Erner Uniourrying Cause (Disease or injury				
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×	eath certifi attending   I for use as		IF FEMALE: 23c. If yes, outcome of pregnancy			001 D	
Box	atter I for u	clar	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	
o.	The law requires that the death cer tte hes been signed by the attendir bage 2 should be detached for use	Physician/N	1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐	Johns (specify)			
 J	w requires that s been signed t should be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Hecords,	quire an sig uid b	g pa	<u> </u>		1 🗌 Yes	2□No 3 robab	ly 4 🗆 Unknown
ပ္သ	s bee	Completed	Orlmonary Humatonian		24a. Wasan	24b. Were autops	y findings available
	iician: The lav certificate hes rector, page 2:	E	H. A. H.		autopsy performed?	prior to comp death?	letion of cause of
Vital		Bec	25. Was case referred to medical	26. Place of Death (Ch	1 □ Yes 2 🔼 N	√o 1 ☐ Yes 2	□ No
		10	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other		6 ☐Other (Specify)	
n 01	Attending Physician: r death. sctor: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		Describe how in		
000	eath. or: A	Sati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
DIVISION	or At fler d Nrsct n by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		Location (Street a	and Number or Rural F ite)	loute Number,
_	urs a urs a srel C						
	S C L	edicai	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my knowledge, death (Check only one)  1□ Certifying Physician: To the basis of examination and/or invane)  1□ Certifying Physician: To the best of my knowledge, death (Check only one)	occurred at the time, date and place, and crestigation, in my opinion, death occurred at	due to the cause( t the time, date a	(s) and manner as state nd place, and due to th	ed. e cause(s)
	H 22 나 유	-	and marrier stated.	29c. License number			
	Io the H vithin 24 o the F mplete	¥.	29b. Signature and title of certifier	250. Cicerise Humber		ate signed (Month, Da	y, Year)
<b>,</b>	To the Hospital or Attending Physical Within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	S.	29b. Signature and title of certifier	AA OOOO	3 00-	vate signed (Montili, Da	y, Year)
<b>,</b>	To the H	Me	Jan Dleans CFNP	AC000013	3 07	2   21   20	y, Year)
}	Vithin 24	Me	John Dleane CFNP	AC0000 13	3 0	LIZIZO	y, Year)
	Star Registra	≥ e	Jan Dleans CFNP	AC000013	3 07 SQL	1 mas	y, Year) 12 21834

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 2^{Day} 2012 Joseph Eugene Lancaster <u>3:1</u>5p ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8322 Allentown Road Fort Washington Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 579-90-9285 Country) **Director** 49 Yrs 1 🕱 M 2 🗆 F 3 1962 Usual Residence of Dece 31 DC or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges Fort Washington 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 8322 Allentown Road 20744 United States Was Deced Armed Forces? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 K Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Laborer DPW and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Joseph E. Lancaster Sr. Barbara Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Barbara Boyette/Mother 8322 Allentown Rd. Fort Washington MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 3-3-2012 Suitland, Maryland Funeral Service Li 22. Name and Address of Facility John T. Rhines Funeral Home M01592 3005 12Street NE Washington DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Arrhythmia Medical resulting in death) Due to (or as a consequence of): Examiner <u>Heart Attack</u> Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Year igned by the ar Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ uncontrolled Diabetes Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed certificate 1 Yes 2 No 1 🗌 Yes 2 1 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? After 1 Certificate: 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury 1 Yes 2 No hours after death uneral Director: 2 Accident Investigation 6 Could not be Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4  $\square$  Homicide determined City or Town, State) within 24 hours a To the Funeral I To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 184 D52706 3-2-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashenaji Waktola MD 5804 Baltimore Ave. Hyattsville MD 20781

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 52012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\overset{\text{Day}}{2}012$ Month March 2, 7:30 p.mM Ledford Helen Pearson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 39340 Ledford Drive Clements St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Min (Month, Day, Year) Director 239-10-5567 1 🗆 M 2 💢 F 93 05/31/1918 Usual Residence of Decedent North Carolina show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f 1 ☐ Yes 2x No Maryland St. Mary's Clements 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 39340 Ledford Drive 20624 United States ed other than "natural", or items event, the Medical Examiner mu and 2 should be filed within 72 hours after death 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Housing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. မ John T. Pearson Mary Edith Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39350 Edmonds Lane, Clements, MD 20624 Bruce Ledford / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Charles Memorial Cem 03/10/2012 Leonardtown, MD permit. 21, Signatur, of Eur rol Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsireld, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ENERSOVASCULAR Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or injury signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HIPENTENSIEN Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has After this certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA pletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

2) ene State 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder S. 24035 Three Notch Road, Hollywood, MD 20636 M.D.

29b. Signature and title

2. Registrar's Signature MAR 0 8 2012

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 08327 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Leonard H. Lockhart, Sr. <u>5:3</u>8₽ ^M 2012 **February** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ceci1 4 Park Circle Rising Sun If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign XXM 2 DF Days Hours (Month, Day, Year) 02/26/1927 Country) Director 411-32-1546 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21921 4 Park Circle 12. Was Decedent Ever in U.S. Armed Forces?

1 ፟፟፟፟ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important, If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Legal Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isaac Ruben Lockhart Clemmie Hurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Park Circle Rising Sun, MD 21911 Kathleen Lockhart - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 02/29 4 ☐ Donation 5 ☐ Other (Specify) T.Foard Funeral Home, PA Rising Sun, MD Funeral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, PA 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Domentia Physician/ disease or condition Unhnum Medical resulting in death) **Examiner** Cerebonovasculas Hocicles Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying physician and s the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical nding p IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown P.0. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 4 hours after death. uneral Director: Aft ed filled in by the fur 2 Accident 1 Yes 2 No Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

of Vital Division Hospital 24 hours Funeral completed within 2

Box 68760

5+ IVA

State Registrar

29a. Certifier

only one)

29b. Signature and title of certifier

Jack Low 5 MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S. Saddev MD, 126 A. F. Minh ST

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

20023322

Elklan MD 21921:

2.29.2012

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Paul Nelson Linton, Sr. 2012 3:47 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 819 Craigtown Road Port Deposit Ceci1 5. Social Security Number 8. Date of Birth
Dec. 6, 1922 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min Maryland Director 216-16-4498 89 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director Maryland Ceci1 Port Deposit 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 U.S.A. 819 Craigtown Road 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 1 1943-45
If Yes, Give 1947-51
Year or Dates 1947-51 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other transmits. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify 3 Widowed 4 Divorced Specify. White Complet 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground Elementary/Seconday (0-12) College (1-4 or 5+) Aberdeen, Maryland Twelve Years Heavy Equipment Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Howard Nelson Linton Rhoda Elsie Meck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Linton (wife) 819 Craigtown Road, Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, 1 Burial 2 Cremation 3 Removal from State R.A. Ferris & Co., Inc. 02/23/12 4 Donation 5 Other (Specify) Pennsylvania Signature of Funeral Service Lie ²² Name and Address of Facility on & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list executions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 2 1 page 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this . Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, 10+IVA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Feb 22. ^{Day} 2012 3:30PM ^M Louise Lee Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland Golden Living Center Social Security Number Birthplace (State or Foreign Country)

PA 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth Nov 22, 1925 **Director** 235-32-6896 86 28a-f show Page 1 and 2 should be filed within 72 hours after death with the waryenryment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f should you or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Cumberland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14200 Pinto Road SW 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 XWidowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sacred Heart Hospital Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilma Rosskamp Elmer D. Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 14200 Pinto Road SW Cumberland M Nissa Aman MD 21502 niece Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Restlawn Memorial Gardens 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 2/27/2012 MD 4 Donation 5 Other LaVale Specify) 22. Name and Address of Facility all Home, PA Sonature eral Servic 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Immediate Cause (Final Onset and Deat Ph sician/ disease or condition resulting in death) ten 6 month Medical Examiner Cardiomyo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas perform 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier wonsockelle 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walsh Rd Cumber and MD 925 Bishop WONSOCK SHIN 31. Date filed (Month Day, Year) 32. Registrar's Şignature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edward Russell Lynch 02/27/2012 0900 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6941 Box Iron Road Girdletree Worcester 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, **Funeral** Months Days Hours Min 1 **3** M 2 □ F 81 214-28-2825 Director 08/10/1930 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shoot I'm Welical Even in the nutilied at MD Worcester Girdletree Completed by Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6941 Box Iron Road 21829 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🛣 Married 1 ★Yes 2 No If Yes, Give Year or Dates: **1948–51** Specify: White 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Commercial Waterman seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Lynch Alice Elliott ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. Edward R Lynch, Jr/son 6215 Timmons Road, Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Crematory of Delmarva2-29-2012 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE of Fugeral Souvice Licensee 22 Name and Address of Facility

Short Funeral Home will 13 E. Grove Street Delmar, DE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o complic shock, or hear failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions. Examiner Due to (or as a consequence of) and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician s the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed this certificate 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Yes 2 No Other: Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Name and address of person who con

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

poleted cause of death (Item 23a) (Type, Print)

12-01597 Reginald Lizotte

## Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. 2012 1833

eginaid Lizotte	,	1- For State Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Cer			a Mental H		eg. No.	
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)		Reginald R. Lizotte  4a. Facility Name (if not institution, give street and number)	4				4c. County of Death	
· .		Peninsula Regional Medical Center  5. Social Security Number	db dough	Salisbury Wicomico  If Under 1 Year If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State				thelese (Clate
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Maryland : 28a-f shov	Director	10e. Street and Number		10f. Zip Code		10	og. Citizen of What Cou	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once.		602 E. State Street  11. Marital Status  12. Was Decedent Ever in U.S.	I 13 Was	2187 s Decedent of His		ecify Ves or No.	U.S.A.	ican Indian, Black,
Baltimore, MD 21215-0036  Departit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Field and Mental Hygier at the "matural", or items 23a or 28a-f sho Important. If item 77 is marked other than "natural", or items 23a or 28a-f sho injary or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Married Armed Forces?	If Ye	es, specify Cuban,	, Mexican, Puerto		White, etc.	
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	nvestigatio	on, in my opinion, 29c. License		the time, date a	and place, and due to the 29d. Date signed (Mon	772-101
C		1111	17	O.C.M			February 24, 201	
350		30. Name and address of person who completed cause of death (I/em 23a)	000:	A. Delain	Ct	MD 040	100	
	tate	Russell Alexander MD. Assistant Medical Examiner  31. Date filed (Month, Day Year) 32. Registrar's Signature		N. Baltimore \$	otreet, Baltim	ore, MD 212	23	
Ponis	tros	FEB 28 7012 12 1 A	book	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Ruby L. Lewis Fobruar 0750 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Glen burne Anne Ary Washi Medical pton 6. Sex f Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Hours Min (Month, Day, Country)
Illinois **Director** 1957 <u>579-78-9702</u> Usual Residence of Decedent show er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1

X Yes 2 □ No Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 564 Stoney Hill 21113 USA Court 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 Specify:Black If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Adventist Health Elementary/Seconday (0-12) College (1-4 or 5+) Health Counselor Care 12th 0 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file, and Mental H 2 Lucille Fenell John H. Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3298 Ft. Lincoln Dr. Washington, D.c. Department of Health at Important; If item 27 is any injury or Att 20018 D.c. Tiffany Smallwood (Niece) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crematory 2/27/12 baltimore, Md. Metro 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, 21, Signature of Funeral Service Licenses Jarry 1922 Forest Dr. Annapol 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Kenal disease or condition resulting in death) Medical **Examiner** respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed and -tran Due to (or as a consequence of): physician a sthe burial-Physician/Medical Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months? jo Month Day Year Pregnant at time of death 1 Yes 2 7 9 Unknown the Unknown detached P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? this certificate Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 No မ 1 KInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director; After Natural 5 Pending work 1 🗌 Yes 2 No hours after death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Mo Registrar

Most

one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2003

714

2/19/12

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryl		artment of F tificate of L		ıvientai Hy	giene Reg. No. 2 (	112	08333	3
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	Physicia Medic	al	Mary Cecilia	Miller	r			Februa	ry 2/,	2012	7:25 am	_
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-	Funeral		Social Security Number     6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bir	th		place (State or Foreign	-
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9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🍱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	I	f Yes, specify Cuba		erto Rican, etc.)	Bla Specify	ck, White, Wh1t /:	etc. <b>e</b>	
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Baltimore, Maryland 21215-0036	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Removal from State	te of Hea	natory or other place aven Ceme	tery	arch 3,	20c. Location Silver	Spri	ng, MD	
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ou	ending eath. or: Afte he fun	ficat	1 → Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Yea	r) injury	M 1 🗆	<br Yes 2 □ No					
Oivisi	al or Atte s after de il Directo ed in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location ( City or To	Street and Numb vn, State)	er or Rura	l Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial person person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the person of the pe	Medical	(Check 2 Medical Examine	cian: To the best of my krer: On the basis of examin Practitioner to the best	ation and/or inves	tigation, in my opini	on, death occurre	ed at the time, date	and place, and du	ue to the ca	iuse(s) and manner stated	d.
	d withing		29b. Signature and title of certification	Rosey	L	29c. Licens D0	e number 9834		29d. Date signe			_
	,		30. Name and address of person who cor Barry Rosenbaum,	mpleted cause of death (	ltem 23a) (Type, F Farragut	Print) Avenue,	Kensin	gton, MD	20895			
ı	Stat Registra	te ar	31. Date filed (Month, Day Year) 2012	2. Registrar's Si	gnature pa	phis.						

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For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milton Mills Month Haro1d 7:07P M ,2012 ebruary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Community Hospital Lapham Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Months Min. 1 X M 2 🗆 F Days Hours 70 228-50-3260 Director Yrs. Washington, D.C. 1941 August Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f 1X Yes 2 □ No District of Columbia Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or with t Funeral 78 - 55th Street, S. E. 20019 United States 12. Was Decedent Everin U.S. Armed Forces? **US Air** 1 **A** Yes 2 NForce 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates. **Black** "natural", Completed 3 Widowed 4 Divorced Specify: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working D.C. Department of than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the 11th grade Towing Operator Public Works Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lucius Mills Myrtle Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Lorraine Reddick (Daughter) 10604 Wood Pointe Terrace; Glenn Dale, Maryland 20769 Department of Healti Important: If item 2 any injury or other t other! 20a, Method of Disposition 20b. Place of Disposition (Name of X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cemetery Quantico, Virginia CC0333 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ladale Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, many, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 L Fetal dea Ectopic pregnancy in the past 12 months? Month Day ned by the at edetached for Yes 2 No been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ requires 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy To the Hospital or Attending Prystocommunity 24 hours after death.

To the Funeral Director. After this certificate Particle of the Funeral Director. After this page. perform 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Site 229, Glenn Dale, MD. Abdella, mD. 12200 anapolis Rd. 31. Date filed (Month. Day. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Edward Emerson Mayor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hagerstown Lutheran Villag avenu Washington | Months | Days | Hours | Min. | April 4,1918 Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 93 Mary Land 155-03-4117 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evaniting must be notified at 1 □Yes 2 No Maryland Washington County Williamsport Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21795 U.S.A. 16901 Hampshire Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify. Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Old Work Mechanic Construction Co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margie Moore Carey Edward Dewey Mayor, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16901 Hampshire Dr. Williamsport, MD 21795 Mary Marcia Mayor-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 3-5-2012 Smithsburg, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consenience of): Lei /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed Examir burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown icate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: completely filled in by the 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 368

30. Name and address of person who completed cause of the th (Item 23a) (Type, Print)

32. Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:49A M February Arlene Rebecca Morgan Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 220 34 9050 Director 1 M 2 X F 77 11/06/1934 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Great Mills St. Mary's MD 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20634 USA 45557 Boyne Court 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", 3 🗌 Widowed 4 🗎 Divorced Specify: Black Year or Dates event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Private Housekeeping and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Rosemary Holland Thomas Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19880 Piney Point Rd. Valley Lee, MD 20653 Rose Morgan / Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State St.Marks UAME Cem. 3/9/2012 Valley Lee, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home <u>38576 Brett Way Mechanicsville,MD20659</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. +nfurution Immediate Cause (Final ocar dial Onset and Death 0 531 m Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for de a consequence of Exami Cause (Disease or injury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 24 hours after death.

• Funeral Director: After this certificate I letely filled in by the funeral director, pag 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural 5  $\square$  Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Physician/ Humberto Jose Martinez 2012 Medical Eacility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** WicomiLo 6. Sex 1 M 2 □ F 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Min. Month Day Y Mexico Yrs 212 76 4657 61 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Items 23a or 28a-f sho her must be notified at irector 1 ★ Yes 2 □ No Berlin MD Worcester ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 West St. 21811 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. event, the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò þ 1 Never Married 2 Married 1 🗷 Yes 2 □ No Specify: Mexican If Yes, Give Year or Dates timore, Maryland 21215-003 Specify: Hispanic "natural" 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) William Esham, Sr. Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha 6 maintenance/ caretaker Admiral Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Francisco Martinez Puente Esperanza Hernandez Salinas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10004 Orchard Rd. Berlin, MD 21811 Donna Scott (stepdaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3/5/2012 Evergreen Cemetery Berlin, MD 21. Si 100 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ UBN Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Other (specify) signed by the at d be detached for 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 X No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 2 24a. Was an autopsy After this certificate has funeral director, page 2 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 2) No Other: 1 🗌 Yes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 No Accident Investigation 24 hours after death Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAR 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2 [] | 2 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 3:25 PM Michael Glen Mays, Sr. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital Social Security Numbe Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2  $\square$  F Months Days Hours 12/23/1947 214-50-1751 64 Maryland Director Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director 1 ☐ Yes 2 No 28a-f Mechanicsville St. Mary's Maryland 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? must be r Funeral 20659 USA 28765 Hancock Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner rmed Forces? █**X** Yes 2 □ No Black, White, etc. 0 þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.
Item 27 is marked other than
other traumatic event, the Me life DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Dry Company Drywall Mechanic 12 Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred Margaret Huster Raymond Stanley Mays, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Margaret E. Mays/ Wife 28765 Hancock Drive Mechanicsville, MD 20a. Method of Disposition 20h Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State ō Department of Important: If any injury or once. 03/12/2012 4 ☐ Ponation 5 ☐ Other (Specify) Maryland Veterans Cheltenham, Maryland of Funeral Service Liden 22. Name and Address of Mattingley-Gardiner Funeral Home, PA 41590 Fenwick Street Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Examiner 1) GEARS SLEWN CONOWART Sequentially list conditions r any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 NZCHAEL IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be HYPERTENSION 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of PENZPHENAL VASCULAR DESCASE 24a. Was an has ' page 2 autopsy perforr death? Hospital or Attending Physician: The certificate 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending after death. Director: Aft Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Within 2 only one) 29b. Signature ar 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUCE ROBERT GERSON MP 25500 POTUT LOOKOUT ROAD LEONARITOWN 31. Date filed (Month, Day, Year) Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of Mary		artment of h			ene 0   2	08339
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physicia		David Rex	McVeigh				Month March 1	Day Year	2:04 p.m.
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Death	IMICH I	4c. County of Death	
	LAdilliii	CI	St. Mary's Nurs	ing Contor		T	1.		St. Mary	1.0
-	Funeral				yrs. last birthday)			8. Date of Birth		nplace (State or Foreign untry)
ш	Director		217-46-7546	1 □XM 2□ F	3 Yrs.	Months Days	Hours Min.	(Month, Day, 1 09/20/1		Texas
	to		Usual Residence of Decedent					32/20/2	7.10	TONOS
	rylar	_	10a. State 10b. County	10	c. City, Town or Lo	ecation				10d. Inside City Limits
	Ba-f s	cto	Maryland St.	Mary's		Avenue				1 ☐ Yes 2√2 No
	ith th	Jire	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	untry?
	23a	by Funeral Director	37470 River Spr	ings Road		20609	9	U	nited Stat	es
	r des	Ine	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
98	or II	Y.F.	1 Never Married 2 Marrie	d 1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 ☐ No			Specify: Whi	
21215-0036	172 hours after death with the Maryland "neture!; or Items 23a or 28a-f show refeal Examinational be multiped at	d b	3 Widowed 4 Divorced	Year or Dates:						
Ų.	"net	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ding 1	3b. Kind of Business/I	ndustry
12	within ene. then "	d.	Elementary/Secondary (0-12)	College (1-4or 5+)	7/10.		,		A 4	
	be filed within 72 hours after death with the Marylan at altygione, and thy filen. And they then "neture!, or liems 23a or 28a-f show event, the Marylan Examination as be multipled at		1.2 17. Father's Name (First, Middle, Li	asti		Mechanic		e (First, Middle, Ma	Auto	
ano	ntal ed o ed o	Be		,					adon Samamo,	
$\frac{2}{5}$	should be nd Menta marked matic ev	^L	Carl F. McVeigh  19a. Informant's Name/Relationshi	n (Tuna Print)	10h Mailie	a Address (Street	Mary H.		City or Town, State, Z	in Code)
Maryland	d 2 s th an 7 is treu								CHURN NO	99
ď	1 and 2 Health tem 27 i		Barbara Ann McV		3 / 4 / ( 0b. Place of Dispo	) River S	prings Ro	Date Aveni	ue, Maryla	nd 20609
و	ages nt of : If it		1 ☐ Burial 2 ☑ Cremation 3	Removal from State	cemetery, crei	natory or other pla			•	
Baltimore,	rtmer rtant rtant		4 ☐ Donation 5 ☐ Other (Special Signature of Experience Service Line)		Brinsfie]	d-Echols	e em late		Charlotte	
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic engue.		Toutell			2. Name and Addre	Bri		Funeral Ho	
	40200		23a. Part 1. Enter the disease, or c	nsfield, Jr. N		22955 Hol	lywood Ro	ad, Leon	ardtown, M	
J.			shock, or heart failure. List or	nly one cause on each line.	death. Do not ent	er the mode of dyll	ng, such as cardiac	00000		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Hencel	Lell	ance	nong	Mell	STATIC	
	/Medical Examiner			Te to (or as a co	insequence of):		,			
		_	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	insequence of):					
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	), 200 to (or do d or						
	xecu and	xar	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):					
68760,	ate be executed hysician and the burial-transit	caiE								
587	ficate phys			d						
×	death certifica e attending ph d for use as th	/Me	IF FEMALE:	23c. If yes, outcome of pr	regnancy				23d. Date of deli	ven/
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐ 4☐Pregnant at time		Ectopic pregnanc Other (specify)	у		Month	Day Year
	the d y the ched	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown						
ص	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as the	by Physician/Med	Part II. Other significant condition	s contributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	uires sign							1 🗆 Yes	2 □ No 3 □ Pro	obably 4 🛣 Unknown
00	w requir been si should	Completed						24a. Was an	24h Were aut	topsy findings available
Re	has ge 2	d L						autopsy performe	prior to c death?	ompletion of cause of
			00.144					1 Yes 2	No 1 ☐ Yes	2 No
Vital Record	Physicien: The far this certilicate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		_ Ott		h (Check only one)		
of	Phys r this	. To	1 Yes 24 No 27. Manner of Death	1 Inpatient	2 ER/Outpatier	I 3L DOA	4 LA Nursing Ho	28d Describe how	ce 6 Other (Spec	eify)
on	Attending r death. ector: After by the funer	tion	1 X Natural 5 ☐ Pending	(Month, Day Ye	ar) Injury	Wo	rk? Yes 2 □ No		many dodantoo	
S	deat deat ctor: / the	ica	3 Suicide 6 Could no	t be	At home farm str			28f. Location (Stre	et and Number or Ru	ral Route Number
Division	after Dire	Certification:	4 ☐ Homicide determin	building, etc. (S	pecify)	oot, idetory, omeo		City or Town,		,
_	To the Hospitel or Attending Phywithin 24 hours after death.  To the Funeral Director, After this completely filled in by the funeral completely filled in by the funeral.	ai C	29a. Certifier 1 Certifying	Physician: To the best of m	v knowledge, death	occurred at the ti	me, date and place.	and due to the cau	Ise(s) and manner as	stated.
	24 h 24 h 3 Fur etely	edicai	(Check only 2 Medical Ex	xaminer: On the basis of exa and manner stated.	imination and/or in	vestigation, in my o	opinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
	vithin To the	Me	29b. Signature and title of certifier	-		29c. Licens	se number	290	d. Date signed (Month	n, Day, Year)
			· Inn I	2 Ptun		ni	4285		3-7-1	>.
_	me		30. Name and address of person w	ho completed cause of death	(Item 23a) (Type		1 -0)		J - 1	
5)	eme		William D. Boyd	TT M D 2536	5 Point	Toolsout 1	Dood T	n o m d +	MD 20450	
	Sta	te	31. Date filed (Month, Day, Year)	32/Registrar's	Signature	LOOKOUE	road, Leo	uaratown,	YUZU650_	
	Registr		MAR U 7	2012 Registrar's	p. 40	we				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 20, 2012 19:00 P M AGNES IRENE MOWLL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CECIL UNION HOSPITAL ELKTON 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Days Hours Min  $exttt{JANUARY}^{(Month, Day, Year)}{ exttt{21}}$ DELAWARE Director 84 ,1928 221-16-8634 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD CECIL ELKTON 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 COMMERCIAL PLAZA 21921 UNITED STATES Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ഉ STANLEY COOK BORUTA ANNA and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i GARY D. MOWLL / SON 6 COMMERCIAL PLAZA ELKTON, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott FEBRUARY 1 Burial 2 X Cremation 3 Removal from State MAYERDALE CREMATORY 27, 2012 NEWARK, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SPICER-MULLIKIN F.H. 1000 N DUPONT PKY NEW CASTLE, DE 19720 Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. Li Interval Betweer diate ause (Final Onset and Death CEREBROVASCULAR ACCIDENT Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Sue to for as a nonsequence of cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of). attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 238. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe After this certificate 1 ☐ Yes 2 ☐ No. 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined e Funeral I

State Registrar 29a. Certifier

(Check

only one) 29b. Signature and title of ce

within 2 To the 1

MD DOOG 2190 2/21/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA HNAWAZICHAN
2533 AUGUSTINE HEMAN HWY, SUITEA, CHESAPEAKECTY, MD 2

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland /	Department of He			2012 0	83L1
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No Date of Death		e of Death	
Physician/ Medical			Catherine Antionette McCl	eary		Month D		42 M
No.	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Le	ocation of Death	4	c. County of Death	
-			Teninsuca Rigional Medical Conf.  5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) If Under 1 Year	If Under 24 Hrs. 8 r	Date of Birth	HICOMICO	
	Funeral Director		577-12-0596 1 D M 2 X F 92		Hours Min.	Month, Day, Year)		te or Foreign
	t w		Usual Residence of Decedent		30	3/04/191		
	arylanda-fied a	Director		wn or Location				e City Limits Yes 2 X No
	or 28;	Dir	Maryland Wicomico Sal	isbury 10f. Zip Code		100.0	Citizen of What Country?	Yes 2 LA No
	with t	Funeral	28131 Pathfinder Court	2180	1	1.03.	USA	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hisp	panic Origin? (Specify ) Mexican, Puerto Ricar	res or No-	14. Race - American Indian	,
36	after al", or xami	d by	1 Never Married 2 X Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 X No		,, 0.0.,	Black, White, etc.  Specify: White	
9-0	hours natura lical E	Completed	15. Decedent's Education 16.	a. Decedent's Usual Occupation	on	16h	Kind of Business/Industry	
215	e. han "r	dwc	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done dun life. DO NOT use retired)		100.	Title of Dusiness/industry	
121	ed within Hygiene. other than ent, the M	Be C	12 -	Housewife			mestic	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)  Willard Bladen	1	8. Mother's Name (First Mae Ver	st, Middle, Maider onica Ma		
ary	should be fil and Mental is marked raumatic eve			9b. Mailing Address (Street and				-
ž	1 and 2 short Health a litem 27 is		Mary P. Wilson/Daughter				oury, MD 21801	
Baltimore,	e 1 an i of He if iten or oth		20a. Method of Disposition 20b. Place 20b. Place 1 X Burial 2 Cremation 3 Removal from State	of Disposition (Name of erx crematory or other place) MICO Memorial	Date	- 1	Location - City or Town, State	
tim	t. Pag tment rtant: njury o		Par	k .	2/25/2		alisbury, MD	
Ba	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Fuperal Service Licensee	22. Holloway 501 Snow	funeral Ho Hill Rd.,	me Profe Salisbur	essional Assoc cy, MD 21804	iation
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying,	such as cardiac or resp	oiratory arrest,	Approxir Interval I	Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	TSCVD			Onset ar	nd Death
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	cuted	kam	cause. Enter Underlying Cause (Usease or injury) that initiated events c.					
	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence	of):				
760		edic	d					
687	certifi nding use a	M/I	IF FEMALE: 23b. Was decedent pregpant 23c. If yes, outcome of pregnancy				23d. Date of delivery	
Вох	s that the death certific igned by the attending r be detached for use as	Physician/Me	in the past 12 months?  1 ☐ Yes 2 No 4 ☐ Pregnant at time of death				Month Day	Year
P.O.	at the	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting	in the underlying gauge eigen	in Port I	D. D. L. L		
ν, σ.	res tha signed d be d	d by	Tach. Other significant conditions continuating to death but not resulting	in the underlying cause given	III Parti.		use contribute to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of	
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a F	nysician: The nis certificate I director, pag		25. Was case referred to medical examiner?	26. Place	of Death (Check only	1 ☐ Yes 2 😿 N one)	lo 1 Yes 2 No	
<u> </u>	hysic his ce al dire	은	1 ☐ Yes 2 🔀 No Hospital: 1 💢 Inpatient 2 ☐ ER/O		4 Nursing Home 5	5 Residence	6 Other (Specify)	
100	ding F	Certificate:	1 📈 Natural 5 □ Pending (Month, Day, Year)	Time of injury at work?		Describe how inju	ry occurred	
Siol	Atten r deat ctor: by the	rtific	2		s 2 No	ocation (Street ar	nd Number or Rural Route Nu	mher
Division of Vital Records,	al Or a		4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, State		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Nedical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, only one) 1 Certifying Nurse Practitioner: To the best of my knowledge, only one) 2 Certifying Nurse Practitioner: To the best of my knowledge, only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, only one) 3 Certifying Physician: To the best of my knowledge, only one) 3 Certifying Physician: To the best of my knowledge, only one) 4 Certifying Physician: To the best of my knowledge, only one) 4 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 6 Certifying Physician: To the best of my knowledge, only one) 6 Certifying Physician: To the best of my knowledge, only one) 7 Certifying Physician: To the best of my knowledge, only one) 7 Certifying Physician: To the best of my knowledge, only one) 8 Certifying Physician: To the best of my knowledge, only one) 8 Certifying Physician: To the best of my knowledge, only one) 9 Certifying Physician: To the best of my knowledge, only one) 9 Certifying Physician: To the best of my knowledge, only one) 9 Certifying Physician: To the best of my knowledge, only one) 9 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Phy	or investigation, in my opinion, of	death occurred at the tir	me, date and place	e, and due to the cause(s) and i	manner stated.
	To th comp	Σ	29b. Signature and title of certifier	29c. License nu			ate signed (Month, Day, Year)	
			Mahnen	D6	0515	21	123/12	
	IOTO		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	-100 - 20	<i>C</i> 1	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	5-11
	Stat	0	31. Date filed (Month, Day, Year) 32. Segistrar's Signature.	ENTSIEHN SI	HUKE IK	SAUSH	RURY MOZIE	04
	Registra	ır	31. Date filed (Month, Day, Year) FEB 2 7 2012 32. Segistrar's Signature.	pares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Florence Gail Miller February 26, 2012 Medical 10:52 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5305 Wye Creek Drive Frederick Frederick **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Ma Month, Days 27 7. Age (In yrs. last birthday) 1 - M 2 X F 9. Birthplace (State or Foreign **Director** 180-20-9603 Pennsylvania Usual Residence of Decedent show with the Maryland at 10a. State 10b. County Director 10c. City, Town or Location r 28a-f s notified 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number ms 23a or must be Funeral 10f. Zip Code 10g. Citizen of What Country? 6441 Jefferson Pike 21703 United States filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? ö þ 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. "natural", Completed 3 X Widowed 4 Divorced If Yes, Give 1 ☐ Yes 2 🛣 No Specify. Year or Dates White Specify M-dical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry than. Elementary/Seconday (0-12) ag th College (1-4 or 5+) and Mental Hygie Is marked other Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Mayer Birdie Mansfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 27 Gayle Shaw / Daughter 5305 Wye Creek Drive, Frederick, MD 21703 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of

veterafia Cemetery Cremetery Cemetery

copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.

Marchate1.

Resthaven Funeral Services,

9501 Catoctin Mountain Hwy.

2012

Physician/ Medical Examiner

nse

Hospital or Attending Physician: The law requires that the death certificate be

has

Director:

a 24 hou. dhe Funeral Dire

within 24 ho To the Function

Division of Vital Records,

Box 68760

Metabolic Acidosis Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hypertension that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy 2 🔯 No Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by UTI, Pneumonia, Atrial Fibrillation, Dementia Be ( 25. Was case referred to medical 26. Place of Death (Check on examiner? မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Other: Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 1 X Natural (Month, Day, Year) 28d 5 Pending iniury

Bradyarrhythmia

Due to (or as a consequence of)

23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed?  1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
ly one)
Daughter's
. Describe how injury occurred
Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

Year

Month

20c. Location - City or Town, State

Cumberland, Maryland

Frederick, MD 21701

Approximate

Interval Between

Onset and Death

Skkot Cody P.A.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

acke

work?

2 No

29b. Signature and title of certifier D0064568

29d. Date signed (Month, Day, Year) February 27,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation 6 Could not be

determined

1 🗵 Burial 2 🗌 Cremation 3 🔲 Removal from State

5 Other (Specify)

4 Donation

resulting in death)

Accident

Suicide

4 🗌 Homicide

21. Signature of Funeral Service Licensee

23a. Part 1. Enter the disease, o

shock, or heart failure. Li Immediate Cause (Final disease or condition

Vivian C. Dechosa, M.D. 610 Solarex Ct., Frederick, MD 21703 31. Date filed (Month, Day, Year) FEB 2 9 201 32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
Amended,	#7,	For TCHD, 3/8/201 State of Maryland / Department of Health and Mental Hygiene TLS	. 2
Amended	#9	1 - State Registrar FH, 2/28/12, TCHD, r1s Certificate of Death Reg. No.	J
Physic Me	cian/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  O2 - 25 - 2012 12:45 P	М
Exan	niner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
Funer		103 Hammond Street Easton Talbot  5. Social Security Number 6. Sex 76 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 M 2 XF MD Country)  7.12 - 4.12 - 73.59 1 M M D Country) Yrs Min. (Month, Day, Year) 1 M D Country) 4 M M D Country)	gn
Directo	or	Usual Residence of Decedent    Second Second Vision   Control   C	
aryland a-f show fied at	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit 1 X Yes 2 1	
the Ma a or 28 be noti	i j	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	-
ath with	Funeral	103 Hammond Street 2160 USA  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,	
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	è	1 Never Married 2 Married 1 Yes 2 No	
15-0 2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working  16b. Kind of Business Industry	$\exists$
laryland 21215-0036 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", o aumatic event, the Medical Exam		Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) Janitor Hospital-Cleaning Secondary	Vie
laryland 212 should be filed within and Mental Hygiene, is marked other the aumatic event, the I	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surrlame)	
Maryland 2 should be filed th and Mental Hy 27 is marked out traumatic event		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	-
nd 2 sh ealth ar m 27 is		Shanika Macer daughter 7213 Pahls Farm Way Pikesvilk, Md. 21208	
nore	1	20a. Method of Disposition  Date  20c. Location - City or Town, State  Place of Disposition (Name of cemetery, cematory or other place)  Date  20c. Location - City or Town, State  20c. Location - City or Town, State  Removal from State  Richard & Memorial 3-3-2012 Easton, Md	
Baltimore, M permit. Page 1 and 2 & Department of Health Important: If item 27 any injury or other tr.	<u>s</u> j	4 Donation 5 Other (Specify)  Richard 5 Memorial 3-3-2012 Easton, Md  21. Signature of Funeral Service Licensee 2 1 22. Name and Address of Facility 426 Dove 75t.	$\dashv$
<b>™</b> #9 # #	5	Bennie Smith Funeral Home Easton, Md 21601	_
Physician	,	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final  Approximate Interval Between Onset and Death	
Medica	al	disease or condition resulting in death)  a.     Due to (or as a consequence of):   Suparts	-
	<b>.</b> .	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. ———————————————————————————————————	_
e executed cian and urlal-transit	Examiner	Cause (Disease or linjury that initiated events  c	_
be exe sician a	<u></u>	resulting in death) Last  Due to (or as a consequence of):	
68760 sertificate buding physic	Medi	IF FEMALE:	$\equiv$
Box death c	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1   Ves 2 DANo 9   Unknown	
P.O. that the ned by the detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	$\exists$
rds, equires een sig nould b	eted	1 Yes 2 No 3 Probably 4 Unknow	
Division of Vital Records, all or Attending Physician: The law requires s after death:  In Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed	24a. Was an autopsy prior to completion of cause of performed?	,
al R ian: Th rtificat ctor, pa	Be Co	1   Yes 2   No   1   Yes 2   No   25. Was case referred to medical examiner?   26. Place of Death (Check only one)	$\exists$
f Vit	은	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
on on or ading Fath:	cate	27. Manner of Death  1 Natural 5 Pending 28a. Date of injury (Month, Day, Year)  28b. Time of injury at work? 1 Note of injury at work?	
visic or Atter fiter des director in by th	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)	
Spital or hours a neral D	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.	$\dashv$
the Ho hin 24 I the Fu	Med	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ted.
o vii		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
		30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  May S: De Shields, My Sog Tdlewild Are Ste Easton, My 2160	$\dashv$
RS 5		May S: De Shields, my S09 Tdlewild Are Stel Easton, my 2160	(
St	ate	31. Date filed (Nonth Par Yea 8 2012) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 08344 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 24, 2012 5:53 Samuel McKee Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Health Center Bowie 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs Min. Hours **Director** 1 XM 2 □ F Feb. 24, 2012 | Maryland Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f shordical Examiner must be notified at 10a, State 10b County 10c. City, Town or Location Director 1 Yes 2 No CA Santa Clara San Jose 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6502 Grapevine Way 95120 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 X Never Married 2 Married 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Molly Delaney Graydon McKee ye 1 and 2 should it of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Molly McKee/ Mother 6502 Grapevine Way San Jose, CA 95120 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important; Many or 4 ☐ Donation 5 ☐ Other (Specify) 2/26/2012 Waldorf, MD **Huntt Crematory** 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Prematurity disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Asystolic Arrest Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death the i signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Respiratory Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perforn death? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗶 No Other: 1 Inpatient 2 XER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 27, 2012 D0060545 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Alfie Mingo, M.D.

Registrar's Signatu

15001 Health Center Drive Bowie, MD 20716

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per fh 6926 4-5-12 of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M9012-27-21012 6:14 a_M Ernest Lloyd Mitchell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1011 Owens Rd. Oxon Hill Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 Days Hours Min. 10-19-1917 **Director** Washington, DC 94 063-05-4771 shov 10a. State with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 ☐ No Prince George's Oxon Hill 10e. Street and Number r items 23a or ner must be n ò 10g. Citizen of What Country? 10f. Zip Code Funeral 20745 United States 1011 Owens Rd filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give "natural", or iten edical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Nidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Inventory Management Officer US Navy Department of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Lloyd Ernest Mitchell Sr. Irene Compton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Diane M. Cheatham/Daughter 4221 Cornwell Ct. Upper Marlboro MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-03-2012 Lincoln Memorial Suitland, MD 21. Signature of Funeral Service 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood MD 20722 23a. Part 1. Enter the disease, or that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, complication Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) Ventricular Tachvcardia Medical Due to (or as a consequence of) Examiner Ischemic Cardiomyopathy Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Atherosclerotic Coronary Artery Disease burial-tran and that initiated events resulting in death) Last attending physician I for use as the burial Physician/Medical death certificate be Dyslipidemia P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the a To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>2</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 L Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 4 ☐ Nursing Home 5 Kesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death al Director; After the 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 0 02/29/2012 D0040576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3301 New Mexico Ave NW Washington, DC 20016 suite 316 Date filed (Month, Day, Year 32. Registrar's Signature State MAR 0 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G930, 8/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 27 2012 6:00 AM Aklog D. Messai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, June 15 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 19<u>34</u> 1 X M 2 🗆 F Hours Director 217-83-2856 77 Ethiopia Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director or 28a-f sl notified Md Burtonsville 1 x Yes 2 No Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 3860 3816 Angelton Court 20866 Ethiopia 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Never Married 2 😾 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ethiopian Government Construction Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Debebe Messai Showa-Tsehaye W/Yohannas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Samson Aklog 16821 Lomond Blvd Shaker Heights, Ohio other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Ft. Lincoln Cemetery 3/1/12 Brentwood, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee . lancis 3401 Bladensburg Rd 20722 Brentwood, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ a Acute Chronic Respiratory Failure disease or condition Medical resulting in death) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Aspiration Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed End Stage Pulmonary Fibrosis Were autopsy findings available prior to completion of cause of death? Acute Myocardial Infarction 24a. Was an autopsy perform 1 Yes 2 No Yes 2X No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred the Hospital or Attending work?
1 Yes 2 No 1 X Natural 5 Pending injury s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) C.M 2/28/12 D0064100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, M.D. 1500 Forest Glenn Rd Silver Spring, MD 20910 Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 1 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 08347 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Parker Nolan Jr. February 29, 2012 5:07 AMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death 5415 Burling Road Bethesda Montgomery Social Security Number 218-24-6326 . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Days Hours **Director** 82 1 🕅 M 2 🗆 F 11/09/1929 Washington, DC Usual Residence of Deci show 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d Inside City Limits Director MD Montgomery Bethesda 1 ¥ Yes 2 □ No 10f. Zip Code 20814 10g. Citizen of What Country' United States 5415 Burling Road Funeral death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner Armed Force 1 ☐ Yes 2 🛣 No If Yes, Give o þ 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 'natural" Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 other traumatic James Parker Nolan Ellen DuBois Peelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ge 1 and 2 sh it of Health a Merlyn R. Nolan / Nephew 4409 Bradley Lane Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 1 Durial 2 X Cremation 3 Removal from State Department of Important: If any injury or once, 03/02/2012 Falls Church, VA 4 Donation 5 Other (Specify) National Crematory ure of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Amyotrophic Lateral Sclerosis disease or condition resulting in death) 10/2009 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) _____ in the past 12 months? Pregnant at time of death Month Dav Year the 9 Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No Yes 2 X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital _2 🔼 No 1 Yes Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 4 Nursing Home funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury To the mount after death.

To the Funeral Director: After the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full of the full 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 48043 02/29/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon A. Scanlon MD 5530 Wisconsin Ave. Suite 1445 Chevy Chase, MD 20815

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day

Year

MAR 0 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O'Connor Marie 2:15 a.m. Medical Ann March 6 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown Mary's Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Hours (Month, Day, Year) **Director** Yrs 156-03-7202 90 New Jersey Usual Residence of Deceder item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No NJ Hudson Jersey City 10e, Street and Number 10g. Citizen of What Country? Funeral 43 College Dr., Apt. 3E 07305 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 ▼ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is mark any injury or other traumatic Thomas McGarry Margaret E. McAndrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Tomaszeski/Daughter 22322 Tanager Way, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of Holy Cross Holy Cross Chapel Mausoleum 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/12/2012 | North Arlington, NJ 21. Signature of Fund al Service Lic 22. Name and Address of Facility Brinsfield Funeral Home Brinsfield 22955 Hollywood Road, Leonardtown, MD M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORDIONSPINATORY disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** CARDIAC A12R4 77700 A Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): and I-transit MYCCARDIAL INFACTION that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical nding p. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Pregnant at time of death Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 2 No 1 🗋 Yes **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending Accident 1 Yes 2 No М Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) mpleted filled in by determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) acolin D69683 3/06/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

LEUNARDTOWN

32. Registrat's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State of M	arylan		partment of I ertificate of I		Mental Hy	•	2012	0 08310
		Registrar  1. Decedent's Name	e (First, Middle, L	ast)			illilicate of i	<u>Jeann</u>	2. Date of De	Reg. No.	2016	3. Time of Death
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certifi ending use as	N N	IF FEMALE: 23b. Was decedent		23c. If yes, outcome			☐ Ectopic pregnan			23	3d. Date of deli	very
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the Ho hin 24 the Fu nplete		only one) 3	Certifying Nu	niner: On the basis of ear Irse Practioner: To the	xaminatior best of my	n and/or inve / knowledge,	death occurred at th	e time, date and plac	t the time, date a ce, and due to th	ind place, a e cause(s) a	nd due to the c and manner as	ause(s) and manner stated. stated.
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State Registra		31. Date filed (Month	h, Day, Year)	32. Registra	ar's Signat	ure						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen Marie Potts March 2012 7:00 a Médical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Taylor Farm Assisted Living Bushwood Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) **Director** 217-36-7716 71 1 M 2 X F 11/08/1940 Maryland Usual Residence of Decedent or 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director St. Mary's Chaptico 1 Yes 2 X No Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20621 25555 Chaptico Overlook Way death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: 3 ₩ Widowed 4 Divorced White Year or Dates or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administrative Secretary Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jefferson Thomas **Owens** Marie Bernadette t. Page 1 and 2 should by thment of Health and Mer rtant; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fr. Ronald Potts/Son P.O. Box 151, Chaptico, MD 20621 permit. Page 1 and 2 Department of Healti Important; If item 2 any injury or other 1 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace 03/08/2012 Helen, Maryland Signature of Funeral Sery 22. Name and Address of Facility
Mattingley—Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 Uchaer 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Haenocarcinoma Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it my local sequences to the Underlying Cause (Disease or injury that initiated events Due to jor as a consequence of Exami burial-transit requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 ass IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Pregnant at time of death Day Year 2 No the page 2 should be detached 9 Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Assisted Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify, 2 XNo 1 🔲 Yes Living မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gentifying Nurse Frantitioner. To the Sent of my Incologie, dueth ordered at the time, date and place, and due to the cause(s) and marrier as state.

(2) pm2

Registrar

State

29b. Signature and title of certifier

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Leon W. Berube, M.D.

31. Date filed (Month, Day, Year MAR 0 5 2012

30. Name and audress of person who completed cause of death (Item 23a) (Type, Print)

D0000506

28170 Old Village Rd., Mechanicsville, MD 20659

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 10:55 DM 2012 Linda Marie Medical Peterson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min (Month, Day, Year, Months Hours Country) **Director** 1 🗆 M 2 🖫 F 060-44-8519 Usual Residence of Decedent Phila PA 10d. Inside City Limits 8-27-1952 28a-f show 10a. State 10b. County 10c. City. Town or Location notified at Director 1 XYes 2 No Upper Marlboro MD Prince Georges 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be Funeral 10621 Campus Way South 20774 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Bace - American Indian Black, White, etc. ð 1 Never Married 2 Married 1 Yes 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: black 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working / Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other th homecare Taig Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Henry Peterson Mildred Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 10621 Campus Way South Upper Marlboro, MD Tameko S. Peterson 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hill Cemetery 2-23-2012 21. Signature of Funetal Se The House of WrightMortuary&Cremation 208 E. 35th St. Wilm DE 19802 eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused t shock, or neart failure. List only one dause on each line. ions that caused the d Approximate Immediate Cause (Final Physician/ Cardiopulmonary Collapse disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Minutes Cardiac Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Metabolic physician and s the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hepatorenal Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Kidney Disease Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Hepotrie Circhosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? Yes 2 Hepatitas Intection 2 X No 1 Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? within 24 hours after deaun.

To the Funeral Director: After t 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February D0052865 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 Annapolis Rd Ste 200 Glena Dale MD 20769 fighes

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day Year) 2 3 2012 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 08352 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Howard Patterson, Jr. 183 Medical 2012 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL MADIONU PANNSULA HICOMIO 544136419 5. Social Security Number If Under 24 Hr If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Months 401-40-9842 Director 1 X M 2 🗆 F 09/14/1933 78 USA Usual Residence of Dece 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21804 USA 620 Hammond Street items ? 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Tes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Construction self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) and Mental 2 James Howard Patterson, Sr. Madelvn Myra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trainonce. Lottie M. Patterson/spouse 620 Hammond Street - Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan UMC Cem 02/25/2012 Princess Anne, MD Sign fun of Funeral Service License 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eptice With Shock Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Duk to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ☐ Pregnant at time of death☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has , page 2 autopsy performed? Yes 2 **X** No death? this certificate 1 Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 **X** No Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npletely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USMAN ZUCFIQAR 100 E.C. ARROLL ST, SALISBURY

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

FEB

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔿 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Marie Elizabeth Punt March 10° 2012° 3:05 P. M Medical 4a. Facility Name (if not institution, give street and number)
33 N. Main St. 4b. City, Town, or Location of Death County of Death **Examiner** Smi thsburg Washington Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours 204-26-7983 77 March Daz Zear 1934 Vrrminia Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Md. Washington Smithsburg 10e. Street and Numbe 10f, Zip Code 10g, Citizen of What Country? Completed by Funeral U.S.A 33 N. Main St. P.O. Box 304 21783 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2√☐ No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 Is and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Cook School 3 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Era Vines Ermon Shifflett Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

r) 33 N. Main St. P.O.Box 304 Smithsburg, Md. 21783 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Elizabeth N. Rohrer(Granddaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) crematory or other place) Green Hill Cemetery Waynesboro, Pa. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 U.L. Davis Funeral Home Smithsburg.Md. WIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State: ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 To the F 29b. Signature and title of 29d. Date signed (Month. Dav. Year) 120050362 30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

of Vital

Division

13424

Pennsylvania

Hagorstown MD 21742

Cantone

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6 2012

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 U for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>012</u> Physician/ MARCH  $\mathbf{a}^{\mathrm{M}}$ ROSE 9:39 SCHIAVONE PEPIORA 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Elkton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 14 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**√** F Hours Days 1922 Yrs **Director** 022-18-2567 89 Massachusetts Usual Residence of Decedent 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ıral", or items 23a or 28a-f s Examiner must be notified Cecil 1 Yes 2 No MD Earleville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1260 Crystal Beach Rd. 21919 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural" Completed 3x Widowed 4 ☐ Divorced Specify: Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med Wheel Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Plant Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. 2 Fedele Schiavone Leonardra Martini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Squier (friend) 24 Club Lane Earleville, MD. 21919 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2. ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dennis Cemetery 3/17/12 Galena, MD. 21. Signature of Funeral Service L 22. Name and Address of Facility Galena Funeral Home of Stephen L. S 118 West Cross St. Galena, MD, 2163 MU0510 118 West Cross St. Galena MD.

The first vield is ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death of the first land of the cause on each line. Approximate uchemi Interval Between Onset and Death abdo Immediate 🛰 e (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗵 No Other: မ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural injury 2 Accident Investigation Could not be the 6 L 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registr State 6 Registrar

IORA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Donafond Physician/ Month 09:50 M rince 2012 02 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University Maryland Baltimore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) 79-84-0682 **Director** 1 🌠 M 2 🗆 F 24-57 Washington 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** be notified Waldorf 1 K Yes 2 No Maryland Charles 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a 20603 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces , or Black, White, etc. 1 Never Married 2 Married Completed by 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 Divorced Black Year or Dates of Health and Mental Hygiene.

item 27 is marked other than "natu
other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lion 1000 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Kichmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prince MA 20a. Method of Disposition 10061 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important; If ite any injury or ot Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Marylan 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fu eral Service Licenses 22. Name and Address of Facility MI) 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pulmonale Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner olmonan Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use of the burnel. unknaun arcoid that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 1 No Other: မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 No Accider
Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 2012 who completed cause of death (Item 23a) (Type, Print) Greene MD 21230

DHMH 17 Rev 06-2011

State Registr<u>ar</u> Registrar's Signat

Down Jodie Quade

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 08356

		1- For State Registrar	Ce	rtificate o		ia montani		eg. No.	2 0000
Physici		Decedent's Name (First, Middle,La					Date of Deat     Month	Day Year	3. Time of Death
Medical Exam	ıner		odie Quad	ie	41 0" T		February 2	29, 2012	1625 hrs
		4a. Facility Name (if not institution, given 25 mile marker on Maypo			Leonardtov	Location of Deatl	n	4c. County of Deat St. Mary's	n
Funeral		Social Security Number 6. S		last birthday)	If Under 1 Yea		s. 8. Date of Birt	h (MM/DD/YYYY) 9. Bi	rthplace (State or
Director		220-78-1847	M 2□F 45	Yr	Months Day		_	Forei	
110		Usual Residence of Decedent	J.:C.		<u></u>			,	
r any		10a. State 10b. County	10c. City,	, Town or Loca	tion				10d. Inside City Limits
land f shov	ō		lary's	Mecha	nicsville	е			1 Yes 2 X No
Mary r 28a ed at	Director	10e. Street and Number			10f. Zip Code		10	ng. Citizen of What Cou	intry?
215-0036 be filed within 72 hours after death with the Maryland ntal Etygiene. rked other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be potified at once.	E D	26938 Laurel Gr		0 140 14	206			USA	to fire Disab
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5 P B	正	3 Widowed 4 X Divorced	1 Yes 2 X No	1	Yes 2 X No	specify:		Specify: W	hite
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be C	, , , , , , , , , , , , , , , , , , , ,	skine			18.Mother's Name			e
Z 2 9 4 2	To B	19a. Informant's Name/Relationship (		19b. Mailin	g Address (Stree			ber, City or Town, State	
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and In Important: If item 27 is m injury or other traumatic		Susan Lynn Quade	/Daughter	249	26 Sotte	rley Rd.	, Hollyw	rood, MD 20	636
re, l 11 and f Heals f item		20a, Method of Disposition  1 X Burial 2 Cremation 3		Place of Dispo crematory or o	sition (Name of ce ther place)	metery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He important: If ite		4 Donation 5 Other Specify	Tremoval from State	t. Jose		03	3/06/12	Morganza,	MD
salti rmit. spartm sports jury o		21. Signature of Funeral Service Lice		²²	Name and Address	s of Facility V-Gardin	er Fune	ral Home, F	·.A.
		Offichaels /	ardiner	4	1590 Fen	wick St.	, Leona	rdtown, MD	20650
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on e	ach line.	. Do not enter	tne mode of dying,	, such as cardiac d	or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
examiner		Immediate Cause (Final disease a. or condition resulting in death)	Multiple Injuries  Due to (or as a consequence of	£/·					Deatri
		Sequentially list conditions, b.		,					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence o	f):					
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'60, cate be executed physician and ne burial - trans	Medical	UNPENDED	AMENDED						
3760, ficate bi g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		etal death 3	Ectopic pregna	ancv	23d. Date of deliver Month	y Day Year
Box 687 death certific the attending p	icial	past 12 months?	4 Pregnant at time of de	oth =	ther (Specify)		arioy	Monay	
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ires that the signed by	by P	Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying cause (	given in Part I.		bacco use contribute to 2 ✔ No 3 ☐ Pro	
an sign	Pe	·					24a. Was a		utopsy findings available
Vital Records ysiciae: The law requi his certificate has been a director, page 2 should	Completed						autops perfor	y prior to	completion of cause of
tal Reco	등						1 Yes 2		es 2 No
iciao: certif	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	FD(0, 1		Other Nursir		2-14	- 2
ing Phys After thi	은	1 Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of		ry at Work?		Residence 6  Othe	r: Scene
Division of Vital Records, rel or Atteoding Physiciae: The law requir rs after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	Ë	1 Natural 5 Pending	Feb 29, 2012	1611 hrs	· ·			ixed object collision	on
r Atte r Atte ler dez irecto n by tl	fical	2 Accident Investigati 3 Suicide 6 Could not	28e Place of Initury - At he	ome, farm, stre	et, factory, office b	ouilding, etc.			ural Route Number, City
Dital o	Certification:	4 Homicide determine		et			or Town, St .25 mile marke	ate) er on Maypole Road,	Leonardtown, MD
Division of Vital Records, P.O. Box 687 To the Hospital or Atteoding Physiciae: The law requires that the death certific within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as it			ian: To the best of my knowledg						
To th Vithir Comp	Medical	29b. Signature and title of certifier	r:On the basis of examination a and manner stated.	ngror investiga	29c. Licens		ar the time, date a		
	3	Zab. Signature and title of certifier	, ,/	1	O.C.			29d. Date signed (Mo March 1, 2012	nur, Day, rear)
		20 Name and address of access the	completed cause of death ("	(222)					
3) eme		<ol> <li>Name and address of person who Zabiullah Ali, M.D. Assi</li> </ol>	completed cause of death (item stant Medical Examiner		Baltimore Stre	et, Baltimore,	MD 21223		
<u> </u>	tate	31. Date filed (MARPa) 75") 201		re					
Regis		מאוז ע ט בטו	2 ferma p.	gar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#12perFH, G928, 6/26/2012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 26 John Lester Ray Sr. February 2012 23:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 8. Date of Birth (Month, Day, Yes Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** Year)192<u>1</u> 1 XM 2 | F Months Days Hours Min **Director** 579-14-7670 90 Pennsylvania Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 20019 United States 5220 Clay Street NE 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 

Yes 2 

Yes Yes 2 

Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African "natural", Completed 3 Widowed 4 Divorced Year or Dates Ämerican Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Supervisor Government traumatic event, Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ be Lester Ray Arlene Dorsey of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 Page 1 and 2 4846 66th Avenue Hyattsville, Maryland Michael E. Ray Sr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March Date ō Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 2012 Landover, Maryland 4 Donation 5 Other (Specify) Harmony 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, T. Slews 20019 MOO560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Chronic Obstruction Pulmonary Disorder disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Congestive Heart Failure and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be funeral director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🏋 No Hospital: မြ 1 A Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) work?
1 Yes 2 No Natural 5 Pending injury M Accident Investigation Director: the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined building, etc. (Specify) 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifie 29c. License number R096053 February 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road Babette Pennay Rockville, Maryland 1. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ILAH **JEAN** RUSSELL 2012 9:41 A.M. March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 21346 Arthur Lane California 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Hours **Director** 213-46-7726 65 1 M 2 X F July 11, 1946 Maryland show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 Tes 2 X No Maryland St. Mary's California 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21346 Arthur Lane 20619 USA items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural" Completed 3 X Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Manager Dry Cleaners Be Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumaria 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Michael Catherine A. Jurovaty Lang, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Philip Woodard (Son) 22653 Athlone Drive, Great Mills, Maryland 20634 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 03/05/2012 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Charlotte Hall, MD 21. Signate of Ineral September 1. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. . brinsfield, Jr. M0005222955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition oan Medical resulting in death) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No þ Month Day Year Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 4 Unknown 1 Tes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law page 2 has autopsy performe this certificate 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Yes Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗌 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred in 24 hours after death. he Funeral Director: After pletely filled in by the funer 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prysidan. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3) Rml William D. Boyd 25365 Point Lookout Road, Leonardtown, MD 20650 . Registrar's Signa

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Brogan Kade Ruppert 2012 March Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 37978 George F Drive Mechanics ville St. Mary's Social Security Number 
 If Under 1 Year
 If Under 24 Hrs.

 Months
 Days
 Hours
 Min.
 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) 1 ▼ M 2 □ F (Month, Day, Year) 10/05/2000 Director 214-59-6145 11 Marvland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Maryland | St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37978 George F Drive 20659 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kobey Shane Ruppert Melinda Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kobey S. Ruppert/Father</u> 37978 George F Drive, Mechanicsville, MD 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State First Saints Community Church Cemetery 103/07/2012 Leonardtown, MD 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Services scensee
Michele Brinsfield M1652 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. ediate Cause (Final ase or condition tino in death) Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No this certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 XNo Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier H0055751 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Deme Jennifer Schmidt, 40900 Merchants Lane, Leonardtown, MD MAR 0 6 2012 Registrar

Box 68760

P.O.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Evangeline Grace March 6:30 p.m™ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>St. Mary's Hospital</u> Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🛛 F Davs (Month, Day, Year) 09/08/1918 **Director** 216-22-1362 93 Maryland Usual Residence of Decedent 28a-f show 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's 1 Tes 2 No Ridge 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 50590 Fresh Pond Neck Road 20680 United States Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or ite þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 event, th Grounds Supervisor Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked or traumatic ever မှ Clarence Douglas Bradburn Rachel Pauline Wilkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Teefey/Daughter 50590 Fresh Pond Neck Road, Ridge, MD 20680 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 03/07/2012 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A Signature Puneral Service dicarcee Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sci in auralio respiraton disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

Division of Vital Records, P.O. Box 68760 o the Hospital or Attending Physician: I ithin 24 hours after death.

o the Funeral Director, After this certifics ompleted filled in by the funeral director, I

EVANGELIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D.

Certificate:

Medical

27. Manner of Death

2 Accident

4 Homicide

29a. Certifier

(Check

29b. Signature and title of certifier

Shah, 22650 Cedar Lane Court, Leonardtown, MD

Date of injury (Month, Day, Year)

5 Pending

Investigation 6 Could not be

determined

1 X Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

Registrar

ithin 2

Other:

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1 Yes 2 No

47066

28c. Injury at work?

🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

4 Nursing Home 5 Residence 6 Other (Specify)

20650

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G925 3/27/12 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 Roy Daniel Rogers 2012 12:56 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 42 St. Michaels Court Ceci1 E1kton Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 **Funeral** Hours Min (Month, Day, Year) Country) Months 221-26-8690 **Director** 1 X M 2 🗆 F Yrs. 69 2/27/1942 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 1 No MD Ceci1 E1kton ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 42 St. Michaels Court items ? within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner r 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify. White Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the 10 Ith and Mental Hygier

27 is marked other t

traumatic event, the Machine Operator Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Rogers Hazel Harless 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 1 and 2 s of Health Reva Jolene Rogers - wife St. Michaels Court, Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) .Foard Funeral Home. Rising Sun, MD uneral Service Licens 22. Name and Address of Facility R.T. Foard Funeral Home, PA Signate 259 E. Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? director, page 1 Yes 2 No certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner2 Hospital Other 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 🗌 Other (Specify) pletely filled in by the funeral 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificates 28d. Describe how injury occurred After Natural 5 Pending injury work? 2 No М 1 🗌 Yes Accident Investigation **Director**: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title License number 29d. Date signed (Month, Day, Year, ress of person who completed cause of death (Item 23a) (Type, Print) 0 Name and

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Mo

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12/2012 Physician/ 6:15 AM Dorothy Helen Russell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Calvert Manor Healthcare Center Rising Sun 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) 09/06/1925 Director VA 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Bridge Port WV Harrison 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 24 Millbrook Road 26330 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be Maryland 17 Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Emerson McConnell Ann Petri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Millbrook Road, Brisge Port, WV 26330 Buford Russell - husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD R.T.Foard Funeral Home, PA 21. Signature of Funeral Service Licenses R.T. Foard Funeral Home, PA 22. Name and Address of Facility 70 111 S. Queen Street, Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition years Medical resulting in death) Examiner Atherosclerosis 11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) The law requires that the death certificate be yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

The string of death 5 Other (specify) IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year the 1 L Yes 2 L g L Unknown 9 Unknown Division of Vital Records, P.O. tor: After this certificate has been signed by the funeral director, page 2 should be detac Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Respiratory Failure. Cerebrovascular Acadent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of Artifier 29d. Date signed (Month, Day, Year) 2.13.2012. achders 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sachdev 126 A, E High ST ElbIm MD 21921. 126 A, E

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

**FFR 14** 

6/1925

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAM EBRUARY 2012 HENRY RILEY 4:10A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign) Days Aug 28 1 M 2 🗆 F 78 214-30-7020 Virginia **Director** Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick New Market 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21774 10545 Edwardian Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: white Completed 3 ₩ Widowed 4 □ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Telephone Co District Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file Henry George Riley Grace Atkins other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 10545 Edwardian Lane, New Market, MD 21774 Brenda Kemp, companion Baltimore, 20b. Place of Disposition (Name of Achter Pacific Pacific) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Demoval from State 2/29/2012 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 15 <u>210 W Main St, Emmitsburg, MD 21727</u> 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death PULMONARY Ph_sician/ EMBOHSM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CANCER METASTASIS LUNG WITH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death ed by the detached 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 2 14 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ZF 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

State

Registrar

EB

Oliver L Ride out

A	MENDE	D	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar # 10E, fh, TCHD, 2/24/12, rs Certificate of Death  Reg. No. 2012 0836
			1. Decedent's Name (First, Middle, Last)  2. Date of Death 3. Time of Death
	Physicia Medi	cal	Oliver L. Rideout February Day 18 2012 1014 M
100	Examir	ner	4a. Facility Name (if not institution, give street and number)  The Memorial Hospital  Easton  4b. City, Town, or Location of Death  Talbot
	Funeral Director		5. Social Security Number 212-66-1950 Usual Residence of Decedent  6. Sex 7. Age (In yrs. last birthday) 1
	/land f show ed at	tor	
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Director	Md. Dorchester Cambridge 1 12 Yes 2 No. 10e. Street and Number 70.1 Page 2 No. 10f. Zip Code 10g. Citizen of What Country?
	with th	Funeral	10g. Citizen of What Country?  322 Bradford House 10f. Zip Code 10g. Citizen of What Country? USA
	death r items iner m	/ Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
036	s after ral", or Exami	Completed by	1 X Never Married 2 Married 1 X Yes 2 No If Yes, Give Specify: Specify: Black
15-0	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working  16b. Kind of Business/Industry
21215-0036	within 7 giene. er than , the M		Elementary/Secondary (0-12) College (1-4 or 5+) 1 College (1-4 or 5+) machine operator  (Give kind of work done during most of working life. DO NOT use retired) Spinning machine operator  E.I.Dupont
	filed v tal Hyg d othe event,	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Maryland	ould be d Men marke matic		Oliver Rideout Elizabeth Johnson  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Rural Route Number City of Town, State Zip Code)
	d 2 shoalth an alth an 27 is er trau		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4718 Payne Road, Hurlock, Md. 21643
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition
Balt	permit. Departi Import any inj		22. Name and Address of Facility Bennie Smith Funeral Home 516 S.Main St., Hurlock, Maryland 21643
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9	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. AND XIC ENCEPHALOPATHY  Due to (or as a consequence of):  Sequentially list conditions.
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	and transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. END STAGE RENAL DISEASE  Due to (or as a consequence of):
0	cate be executed physician and s the burial-transit	edical E	resulting in death) Last  Due to (or as a consequence of):
68760	tificate ng phy s as the	Medi	IF FEMALE:
Box 6	or Attending Physician: The law requires that the death certificate be executed attendenth. Differ death. Differ death. Differ death. Differ cort. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-trans.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   23c. If yes, outcome of pregnancy   1   Ectopic pregnancy   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   Month   Day   Year   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknow
ls, P.O.	v requires that the by should be detacted		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Wunknown
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of Vi	y Physi er this c eral dir	e: To	1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death  28a. Date of injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred
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	Hospita 4 hours Funeral tely fille	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the vithin 2 To the comple	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			John 13012 Do059487 02/18/2012
RS	S IVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John Botsis M.D., 219 S. Washington St., Easton, Md. 21601
	Stat Registra	te ar	31. Date filed (Month, Day, Year) 4 2012 32. Rigistrar's Signature 6.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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and and	Examin		4a. Facility Name (	If not institution, give s	street and number)		1 .	4b. City, Tow	n, or Loca	tion of Death		7	c. County of Dea		
d'			5. Social Security N	Jenior Living	ring of	Man e (In yrs. I	OKIN	If Under 1 Ye		nder 24 Hrs.	8. Date of B	lirth	>011015e	thplace (State	e or Foreign
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/lan	should be and Mental s marked c umatic eve	To B	Alfred Ed	dward McAl	lister				Elv	a Loui	se Wor	kman			
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nor	Pages nent of l ant: If ite ury or o		1 X Burial 2	☐ Cremation 3 ☐ R 5 ☐ Other (Specify)	emoval from State	C	emetery, c	rematory or other  Mem. Gard	place)		2012		bron, N		and
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			shock, or hea	he disease, or complicant failure. List only on	cations that caused e cause on each li	the death ne.	n. Do not e	enter the mode of	dying, suc	ch as cardiac	or respiratory	arrest,		Approxim Interval E Onset an	Between
1	Physician /Medical		Immediate Cause ( disease or conditio resulting in death)				ASW							1040	ars
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Box	ath ce	ian/	IF FEMALE: 23b. Was decedent in the past 12	t pregnant	3c. If yes, outcome 1 ☐ Live birth	2 Fetal	death	3 ☐ Ectopic pregn				4	23d. Date of de Month	livery Day	Year
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=	/sicla	o Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☐	/	ospital:	ent 2 □ I	EB/Outnat	ient 3 DOA	Othori		h (Check only		6 ☐Other (Spe	aiful	
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Division of Vital Records,	l or Al after c Direc	Certification: To	4 ☐ Homicide	determined	building, et	ury - At ho c. <i>(Specif</i> y	me, tarm,	street, factory, offi	ce		28f. Location City or To		and Number or Ri te)	ural Route No	umber,
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, p		29a. Certifier (Check only	1 Certifying Phys	iclan: To the best	of my know	wledge, de	ath occurred at th	ne time, da	ate and place,	and due to th	e cause	(s) and manner a	s stated.	( )
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	or viti	2	29b. Signature and	title of certifier					ense num				ate signed (Mont		
			·	ess of person who con	mpleted cause of d	eath (Item	23a) (Tvn		05/3	77		H	oneary ?	1817 2	0/2
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	Registra	AT		1 1 2 2 2 2 2	sic pene	we	pl. 7	goarres							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 2012 24, 5:00 A M Ruby Gordon Smith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Capital Caring Hospice Prince George's Bowie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🔀 F Oct. 31 Months Days Hours 1911 Virginia Yrs Director 578-32-0838 100 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5362 Chillum Place NE 20011 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Deceuent 2... Armed Forces? 1 ☐ Yes 2 A No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: "natural", 3 Widowed 4 Divorced Completed American the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Private Homemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ Page 1 and 2 should be ment of Health and Ment Frederick Conner Hattie Prillerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Michael Gordon Smith - Son 5362 Chillum Place NE Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date March 1 2012 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Laurel, Maryland Maryland National 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, totes 4001 Benning Road NE Washington, DC 20019 M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 1 Yes 2 g Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed? Yes 2 certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident 1 Yes 2 No within 24 hours after death

To the Funeral Director: / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature an 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar werman mo

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BASIL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AR60

025001

Jay Lippman

02-29-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Henry Swann, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death La Plato Social Security Number 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) **Director** 217-28-8458 1 😿 M 2 🗆 F 82 Usual Residence of Decedent 4/23/1929 Washington, DC injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits · 28a-f 1 ☐ Yes 2 🛣 No MD Charles Indian Head 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 3146 Jenkins 20640 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. ō ģ 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates, 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 X Widowed 4 Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Charles County Elementary/Secondary (0-12) College (1-4 or 5+) be filed within Il Hygiene. Government Baliff - Charles County, MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental 2 Dorothy Cash Cooksey Thomas Henry Swann, Sr. and 2 should the Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 Eleanor Myles / daughter 24632 Maple Valley Lane Hollywood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ö 1 ☐ Burial 2 🌠 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 3/10/2012 Charlotte Hall, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols Funeral Home M00817 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a co Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death signed by the a d be detached f 2 100 Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of ate has bage 2 s autopsy death? 1 ☐ Yes 2 ☐ No 2 - No 25. Was case referred to medical Certificate: To Be lace of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 1 Inpatient ER/Outpatient 3 DOA funeral 27. Mann eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical

within 24 hours a 10 Rme State Registrar

land

Mary

Baltimore,

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 06-2011

29a. Certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State	of Marylar	•	artment o <i>tificate o</i>			1ental Hy		2012	08368
		Registrar  1. Decedent's Name (First, Middle	, Last)		Cei	uncate 0	Deal	11	2. Date of De	3	2012	3. Time of Death
Physici Med		Ruby H. Sylves	ter						Month 02		2012 ^{Year}	4:10 PM
Exami		4a. Facility Name (if not institution,	give street and nur	mber)		4b. City, Towr	n, or Locati	ion of Death	-	4c. C	ounty of Death	
at a second		53 Roberts Way 5. Social Security Number		I		North					Cecil	
Funeral Director		280-20-7453	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Ye Months Da			8. Date of Bi (Month, Da 8-14-	ay, Year)	9. Births Coun	place (State or Foreign try) WV
od now	٦.	Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Loc	eation					1	0d. Inside City Limits
arylar a-fst	Director		Tont 1 o	100.01								1 X Yes 2 No
the M or 28 e noti	į	10e. Street and Number	Castle		WIIII	ngton 10f. Zip Cod	e			10g. Citize	en of What Coun	
with s 23a ust b	Funeral	110 South Scott	Street				1980	)5		U	SA	
Dattimore, IMaryliand ZIZI3-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	ied Armed Fo	2 🔀 No		Vas Decedent of Yes, specify C			cify Yes or No- Rican, etc.)	1	Race - Americ Black, White, e	
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Z15-UU36 in 72 hours after e. Ian "natural", o Medical Exam	Completed	(Specify only highe			i (Give k	ent's Usual Occ ind of work dor NOT use retire	ne during n	nost of worki	ng	16b. Kind	of Business Inc	dustry
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filed all Hyg	o Be	17. Father's Name (First, Middle, L	ast)		•			-	e (First, Middle	Maiden Sui	rname)	
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Mar 2 shou 1th and 27 is m		19a. Informant's Name/Relationsh			1					-	wn, State, Zip C	code)
and 2 s and 2 s Health a tem 27 i		Bonnie Lucas - 20a. Method of Disposition	daughter		53 RC	berts	way,	1	East,		901 ation - City or To	wn State
age 1		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (S	3 Removal from	n State	cemetery, crem	atory`or other p	,	3-2-			ington,	
Daitimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signatur uneral Service		- O							ral Home	_
		1 - ra(. 11	Home								MD 2192	•
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 "Medical Ex	Physician: To the b caminer: On the bas Nurse Practioner:	sis of examination	n and/or investi	gation, in my op	inion, death	h occurred at	the time, date a	ind place, an	d due to the caus	se(s) and manner stated.
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DHMH 17 Rev 7/2009

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٠ .	Medic xamin		4a. Facility Name (if not institution					Location of Death	<u> </u>	4c. County of Dea	ith
1			CALVERT MANOR H				RISING			CECIL	
	uneral rector		5. Social Security Number 500-22-3351	6. Sex 1 <b>XX</b> M 2 □ F	Age (In yrs. Ias 85	t birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth SEPT • 3	9. Bi 0, 1926 MIS	rthplace (State or Foreign
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<b>21215-0036</b> within 72 hours after death with the Maryland giene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 🏿 widowed 4 ☐ Divorced	If You Cive	? □ No NAV	YY If	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: WI	
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Iled w	other rent, 1	Be	17. Father's Name (First, Middle, L	.ast)		Ho	0001171111	18. Mother's Name			<u>.                                    </u>
ylar Id be f Menta	marked matic ev	욘	NED WESLEY SCH	OONOVER				LOA ETH	EL ARMOU	R	
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O 0 2	± 5		20a. Method of Disposition  1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 ☐ Removal from Sta	te CROW	CEMET	sition (Name of Ptery <b>verificals</b> ERY	ns febr	UARY c		E, MARYLAND
<b>Ball</b> permit. Depart	Important: any injury once,		21. Signature of Funeral Service	licensee						ERAL HOME H EAST,MAI	, P.A. RYLAND 21901
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ician	certifi	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			Othe	ace of Death (Checker:			
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Division of Vital Hospital or Attending Physician: 24 hours after death.	e <b>ral Director:</b> After this certific filled in by the funeral director,	l Certificate:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place of It	njury - At hom etc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
To the Hospi within 24 hou	To the Funer completed fill	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of Nurse Practioner: To the	f examination a	and/or investi	gation, in my opinio	on, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
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R	Stat Registra	e ar	31. Date filed (Month, Day, Year)	2 4 20 2 ^{32. Regis}	far's Signatur	<b>B</b> .	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Physician/ **FEBRUARY** 2012 MARY ESTHER ROLLINS STOUT 09:08 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE 9. Birthplace (State or Foreign CountBALTIMORE MARYLAND Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Month, Day, Year)

AN 23,1933 1 □ M 2 💢 F Hours Director 218-28-1481 79 JAN10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 ☐ Yes 2 🋣 No NORTH EAST MARYLAND CECII 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 412 CHAMPLAIN ROAD UNITED STATES 21901 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. A Q 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER SALVATION ARMY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ္ဂ EDWARD WESLEY BIRELY RUTH ESTHER FOSTER and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE CULLUM / DAUGHTER 412 CHAMPLAIN ROAD, NORTH EAST, MARYLAND item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State FEBRÜÄRY Important: If it any injury or o UNITED CREMATORY
SERVICES 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22, 2012 NEWARK, DELAWARE 21. Signatura Francis Principle Licensee 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death neumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Sequentially list conditions, Examine fram leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical ast IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 🕱 No 4 ☐ Pregnant : 9 ☐ Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 2 No page 2 1 Yes 2 No Vital 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🗷 No မ 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) ot 27. Manner of Death 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours a

To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2/20/2012 Medical Doctor 07/056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAURT de Grace MO21078 ANGELIM ESMOILLA 501 SOUTH UNION Avenue

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

				Pleas						Health and		100	gible.	08371
		•	For State Registrar		Ota	10 01 141	ai yiai i		tificate of			Reg. No.	. U . L	00011
	Physicia	in/	1. Decedent's Nam	•	· ·						2. Date of Dea Month	Day	Year	3. Time of Death
	Medic Examin		Janet 1  4a. Facility Name (if	Louise S		d number)			4b. City, Town,	or Location of Deat	02 h	14 4c. Cour	2012 nty of Death	6:50 P M
	LAdmin	CI	Union H	Hospital					Elkto			Ce		
	Funeral Director		5. Social Security N 151-32-6	lumber 6	i. Sex 1 ☐ M 2≹		e (In yrs. la 69	ast birthday) Yrs.	Months Days			h , Year) <b>942</b>	9. Birthp Count	lace (State or Foreign ry) NJ
	ld now	Ļ	Usual Residence of 10a. State					v. Town or Lo	cation				10	0d. Inside City Limits
	farylan <b>3a-f sh</b> tified a	Director	MD	Ceci1					ton					1 ☐ Yes 2X No
	a or 2		10e. Street and Nur						10f. Zip Code			10g. Citizen o	of What Coun	try?
	ms 23 must	Funeral	108 Whit	tmore Dr		Decedent	Ever in II 9	113.1	21921	Hispanic Origin? (S	necify Yes or No-	USA L14 B	ace - Americ	an Indian
920	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	۵	11. Marital Status 1 ☐ Never Marr 3 ☒ Widowed		d 1 🗆	ed Forces? Yes 2 X s, Give r or Dates.		'	f Yes, specify Cult	oan, Mexican, Puer	to Rican, etc.)	В	lack, White, e	etc.
21215-0036	72 hour n "natu fedical	Completed		15. Decedent ecify only highest	grade comp			(Give	dent's Usual Occu kind of work done O NOT use retired	during most of wo	rking	16b. Kind of	Business Inc	lustry
212	led within Hygiene. other than ent, the N		Elementary/Sec	onday (0-12)	Colle	ege (1-4 or	5+)		ing / Re	,		Reta	ail_	
Maryland	ntal Hy ed oth event	To Be	17. Father's Name (		st)						me (First, Middle,	Maiden Surna	me)	
aryla	should be file and Mental H is marked o raumatic eve	į	Dona1d  19a. Informant's Na		(Type, Print)	)		19b. Mailir	ng Address (Stree	t and Number or Ri	Kistner  ural Route Number	r, City or Town	, State, Zip C	ode)
	and 2 sh Health a tem 27 is		Kathleer		a - da	aughte	er	134	Midland	Drive, E	1kton, M			
_				position		I from State	. 0	emetery, crer	sition (Name of natory or other pla Funeral	O2/ Home, P	17/2012		n - City or To	
altir	permit. Page Department of Important; If any injury or once,	1	21. Signatur	eral Service Lic	-	1	/ K.I	22	2. Name and Add	ress of Facility R	.T. Foar	d Fune:	ral Ho	
8	89 <b>=</b> 89		23a. Part 1. Enter	al.	111 /3		145 - 1 - 4			Main Stre			21921	Anaravimata
	hysician/	W 1	shock, or hea Immediate Cause disease or condition resulting in death)	ırt failure. List on (Final	ly one cause	on each lin	PD		er the mode of dy	ing, such as cardia	or respiratory air	631,		Approximate Interval Between Onset and Death
-	Medical Examiner		Sequentially list co	anditions.	b. ——	ue to (or as	1	Cd	abel	os me	11:3n	5)		
	nted d ansit	Examiner	cause. Enter Unde Cause (Disease or that initiated event	nmodiate erlying injury	D	HCU	te.	Res 1	1: rat	on F	ai uv	é.		
0	be executed sician and burial-transit	<u></u> =	resulting in death)		d.	Res	a consequ	ience of):	il me	2.				
68760	tificate ng phy as the	Med	IF FEMALE:			7 0 7								
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd eath.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	23b. Was decedent in the past 12 1 ☐ Yes 2 € 9 ☐ Unknown	months? ⊒ No	1 4	es, outcome Live Birth Pregnant a Unknown	2 Feta	Ideath 3	Ectopic pregna Other (specify)	ncy			Date of delive Month	pry Day Year
s, P.O.	ires that th signed by Id be detac	d by Ph	Part II. Other signi	ficant condition	s contributin	g to death I	out not res	ulting in the u	ınderlying cause g	given in Part I.	23e. Did to	/		e cause of death?
Division of Vital Records,	he law requite has beer age 2 shou	omplete									24a. Was autop perfo 1 ☐ Yes			osy findings available impletion of cause of
tal	cian: T ertifica ector, F	Be	25. Was case referr examiner?	_ /	Hospital:				I o	Place of Death (Che	eck only one)			
>f Vi	Physi rthis o eral dir	e: To	1 ☐ Yes 2 L 27. Manner of Deat			1 Lanpat Date of inju	ıry	28b. Time of	nt 3 L DOA 28c. Inju	4 L Nursing ury at	Home 5 Resid			
ouo	ending sath. or; Afte he fune	ficat	1 Natural 2 Accident	5 Pending	ation	(Month, Da	y, Year)	înjury		ork? □ Yes 2 □ No				
)ivisi	alor Att after de Directe d in by t	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could no determin	28e.	Place of Inj building, et	ury - At ho c. (Spec <i>ify</i>	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		nber or Rural	Route Number,
_	ne Hospita n 24 hours ne Funeral oleted fille	Medical	(Check	Medical Ex	aminer: On t	he basis of a	examination	and/or inves	tigation, in my opi	ne, date and place, nion, death occurred the time, date and p	at the time, date a	nd place, and	due to the cal	use(s) and manner stated.
	Vithii Vomp	-	29b. Signature and	vitte of certifier	100					ise number		29d. Date sig		
	•		30. Name and addr	ress of person w	ho completed	d cause of c	death (Item	1 23a) (Type, I		7174 REET	<del>-   -  </del>	UZ	15 -0	2012
	6		DR. HO		SHEN	1 20	23 1	V. M	AIN ST	REET	EIKTON	1 ML	21	921
	Sta Registr		31. Date filed (Mon	FFR 177	2012	32 Registr	ar's Signat	d. A	all					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Kathryn M. Sampson 2012 Medical 1521 Рм 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Months Hours NOV 27 Year) 929 Director 189-24-9329 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Pennsylvania Philadelphia Philadelphia 1 X Yes 2 No 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6413 Guver Avenue 19142 United States items 11. Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 9 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 marked other than "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify 3 X Widowed 4 □ Divorced White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) uld be filed within? Elementary/Seconday (0-12) College (1-4 or 5+) Area Coordinator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Waggoner Eliza Kochersperger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn A. Sampson/Son 12003 Waldemire Drive, Philadelphia, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State February 4 Donation 5 Other (Specify) Arlington Cemetery 8, 2012 Drexel Hill, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton St., Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Respiratory disease or condition Medical resulting in death) Obspuctive Pol monony Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last burial-transi ard longo pathy Due to (or as a consequence of) Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day be detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à furnillation Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Investigation 6 Could not be Accident completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifie 0.0 400 1182 400 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stohnson D . O Hell 500 Upper Chesapeake Dr., BelAir, MD 21014 31. Date filed (Mont) State 32. Registrar's Signatur FEB Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Kenneth Craig S	Stev	1- For State	State	of Maryla				Health ar	nd Mer	ntal Hy		2		2 0837
Physici	an/	1. Decedent's Name (First	t, Middle,Last	)		, imou	10 01	Dealit		12	Date of Dea	Reg. No.		3. Time of Death
Medical Exami		Kenneth Crai	g Steven	S							Month March 3,	Day Yea 2012	٢	1909 hrs
		4a. Facility Name (if not i	nstitution, give	street and num	nber)		4	b. City, Town, o	r Location	of Death		4c. County of		
		145 South Water						Frostburg				Allegany		
Funeral Director		5. Social Security Numbe			7. Age (In yrs.		day)	If Under 1 Year Months Day	$\rightarrow$	er 24Hrs.		rth (MM/DD/YYYY	Foreig	n
500101		218-60-1118 Usual Residence of Dece		M 2 F		59	Yrs.				Ma	ıy 15, 1952	Cou	untry) Maryland
a ny			County		10c. City	, Town o	r Locatio	on					$\neg$	10d. Inside City Limits
E	_	Maryland	Allegan	y	Fr	ostbur	g							1 X Yes 2 No
te Maryland or 28a-f show fred at once.	Director	10e. Street and Number	145 S. W	ater Stret				10f. Zip Code			11	l0g. Citizen of Wh	at Cour	ntry?
the North								21532-				U.S.A.		
h with	Pra	11. Marital Status		12. Was Dece		.s.		Decedent of Hi						can Indian, Black,
r deat	튑	1 Never Married 2		1 X Yes	2 No	,		s, specify Cuba			ican, etc.)	White		nit o
s afte	à	3 Widowed 4  15. Decedent's Education		f Yes, Give Year or Dates:		140- 0		Yes 2 No				Specify:	Wł	
2 hour	\$	Elementary/Secondary		College (1-				s Usual Occupa st of working life				16b. Kind of Bus	iness/ir	ndustry
D36 thin 7 than edica	Completed by Funeral	12		0	,	Tra	ain Tr	ansportatio	on			Train Tra	nspo	rtation
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or Items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	ပိ	17. Father's Name (First, Clarence Steve				L						Maiden Surname)		
121 d be fi ental	Be									n Durs				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.	٤	19a. Informant's Name/Re Marlene Perkir		Sister		196.	Arms	Address (Streetrong Ave	et and Nur	nber or Rur Frost		nber, City or Town <b>Mary</b>		Zip Code) 21532-
and 2 and 2 fealth item 2 traum	ŀ	20a. Method of Disposition	1			Place of	Disposit	on (Name of ce	metery,		Date	20c. Location -		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cre	_	Removal from	n State	Moun	y or other	r place) Cemetery		March	06, 2012	Finzel		Maryland
altin nit. P artme	H	4 Donation 5 Of 21. Signature of Funeral S		90			22. Na	me and Address	s of Facilit	<u> </u>				
E F P P		Muldes	7D	200			D	urst Funer	al Hom	ie, 57 F	rost Ave.	, Frostburg,	MD	21532
Physician		23a. Part I. Enter the disea failure. List only one	ase, or complic	cations that cau	sed the death	. Do not e	enter the	mode of dying,	such as c	ardiac or re	espiratory arre	est, shock, or hear	t	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final d	sease a.A	therosclero	tic Cardiov	ascula	r Di <b>s</b> e	ase						Death
******	- 1	or condition resulting in de		ue to (or as a co	onsequence o	f):	-	- 412						
	<u>ā</u>	Sequentially list condition if any, leading to immedia	e D	ue to (or as a c	onsequence o	f):						···		
	힐	cause. Enter Underlying (Disease or injury that init	ated C											
nted d ansit	dical Examiner	events resulting in death)	Last d.	ue to (or as a c	onsequence o	1):								
O, e be executed /sician and burial - transit	<u>a</u>	UNPENDED	$\neg$	AMENDED									$\neg$	
	ω⊢	IF FEMALE:		23c. If yes, ou	tcome of preg	nancy			_			23d. Date of d	eliverv	
687 ertific ding p	ian/	23b. Was decedent pregna past 12 months?	nt in the	1 Live birt		2	Feta	death 3	Ectopic	pregnanc	<b>y</b>	Month	Da	ay Year
Box 6876.  c death certificate the attending phy ed for use as the b	Physician/M	1 Yes 2 No 9	Unknown	9 Unknow	it at time of de n	atn 5	Othe	r (Specify)				i		
, P.O. Box 6876( res that the death certificate signed by the attending phys be detached for use as the b	됩	Part II. Other significant of	onditions c	ontributing to d	eath but not re	esulting in	the un	derlying cause g	iven in Pa	irt I.	23e. Did to	bacco use contrib	ute to th	ne cause of death?
res that signed be de	q p	Chronic Alcohol	Abuse								1 Yes	2 No 3	Proba	ibly 4 🗹 Unknown
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Completed										24a. Was a			opsy findings available impletion of cause of
ecc he lav ate has	Ē										perform	med? de	ath? ✔ Yes	
Vital Recc ysician: The lan his certificate ha	Be	25. Was case referred to n		A705-00-00-			•	26.Place	of Death (	(Check only			7 100	2 10
Vit.	2	examiner? 1 ✓ Yes 2 N	Hos	spital: 1 Inp	atient 2	ER/Outp	atient	B DOA	Other ₄	Nursing H	lome 5 i	Residence 6	Other:	Scene
J Of Jing Ph	ᇙ	27. Manner of Death  1 ✓ Natural		28a. Date of (Month, Da	Injury ay,Year)	28b. Tim	ne of Inju		y at Work		d. Describe h	ow injury occurred	I	
SiOl Atten death cetor:	薑	2 Accident	Pending Investigation						es 2					
Division pital or Attencours after death cral Director: filled in by the	Certification:	3 Suicide 6	Could not be determined	(Specify)	or Injury - At no	me, tarm	, street,	factory, office bi	uilding, etc	28	f. Location (S or Town, St		or Rura	al Route Number, City
Tospit Tospit Tuners		4 Homicide 29a. Certifier 1 Certifie		1	f my knowledd	re death	OCCUPTO	d at the time, da	te and ale	00.000	- to the	e(s) and manner a		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:			Examiner: 0	n the basis of e	examination ar							e(s) and manner a and place, and due		
F 3 F 8	\$ ₹	29b. Signature and title of		nd manner state	R.J.			29c. License	number			29d. Date signed	(Monti	h, Day, Year)
3+		M			1	2 1		O.C.N	ΛE.		J	March 4, 201	2	
hal	1	30. Name and address of p		-	•	,		1						
1000		Russell Alexande		sistant Med			900 W	. Baltimore	Street, I	Baltimor	e, MD 212	23		
Sta Registi		31. Date filed (Month, Day,	5 201	1 1/2	strar's Signatu	1. 1	bar	4						
				A SECULO		- 1						CNAF		

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			FOI	aryland / Depa	artment of H	Health and N	lental Hygi	ene	0 00071				
	1 - State Registrar Certificate of Death Reg. No. 2012 08371  1. Decedent's Name (First, Middle, Last)  2. Date of Death 3. Time of Death												
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Gerald Steven	Si	ingleton				3. Time of Death				
and the	Examir		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Dea	ath				
	<i>(</i> -	Į.	Western MD Regional Medic			mberland	I		legany				
	Funeral Director		5. Social Security Number  217-42-6940  Usual Residence of Decedent  6. Sex  1 💢 M 2 🗆 F	8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 05/31/19	(ear) Co	rthplace (State or Foreign ountry) .ryland				
	and show	5	10a. State 10b. County	10c. City, Town or Loc	cation		I		10d. Inside City Limits				
	Maryla 28a-f	Director	MD Allegany	Cu	umberland				1 🎇 Yes 2 □ No				
	with the 23a or 2	Funeral Di	10e. Street and Number 215 Tilghman Street		10f. Zip Code <b>215</b>	02	10	ng. Citizen of What CUSA	ountry?				
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 X Yes 2 Fif Yes, Give Year or Dates.	No If		ispanic Origin? (Spen, Mexican, Puerto Specify:		14. Race - Am- Black, Whi					
21215-0036	hours natura ical E	Completed	15. Decedent's Education	16a, Deced	lent's Usual Occupa	ation	11	6b. Kind of Business					
215	e. nan "r	dmc	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5	(Give F		during most of work	ing		T.				
2	ygien ygien her th		12	Secur	ity Poli	ceman	Ü	J.S. Air F	orce				
Maryland	d be filed Mental H arked ot atic ever	To Be	17. Father's Name (First, Middle, Last)  Calvin  David	Singletor	ı	18. Mother's Nam Genevies	e (First, Middle, Ma 7 e	Marie Marie	Teeter				
Man	d 2 shoul alth and I o 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Benjamin Singleton / Broth			and Number or Rura Jenue, Cu		ity or Town, State, Z , MD 2150					
altimore,	Page 1 an ent of He nt: If item ry or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem Glendale	natory or other plac	e)		Oc. Location - City o					
Balti	permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	22	. Name and Addres		ams Famil	-	Home, P.A. 21502				
r	100	Г	23a. Part 1. Enter the disease, or complications that caused shock, or neart failure. List only one cause on each line	the death. Do not ente					Approximate Interval Between				
pac,	Ph sician/ Medical			E MYO	CARDIA	LIMP	ANCT.	TON	Onset and Death				
lang!	Examiner	,	000	a consequence of):	4	111	SEASO	5					
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence	PELLIT	V VIVE	E7						
	death certificate be executed re attending physician and ed for use as the burial-transit	ai Exa	that initiated events resulting in death) Last Due to (or as a	-		15, TYP	<i>B C</i>						
90	ate by	edical	d. 17 110	ENTENS	SOF								
687	eath certifica attending pl	/Me	IF FEMALE: 23c. If yes, outcome					22d Data of da	divor				
		Physician/Me	1	2 Fetal death 3 = time of death 5 =	Ectopic pregnanc Other (specify)	У		23d. Date of de Month	Day Year				
P.0	es that the dea signed by the a I be detached f	þ	Part II. Other significant conditions contributing to death by			ren in Part I.	23e. Did toba		the cause of death?				
rds	require been signature	eted				70	1 La res		Probably 4 Unknown				
Records,	ysician: The law r is certificate has b director, page 2 s	Completed	ALCOHOLIABUS				24a. Was an autopsy performe	prior to death?	stopsy findings available completion of cause of				
Viital	sician: The certificate irector, pag	Be (	25. Was case referred to medical examiner?			ace of Death (Check			~~~				
Ė	Physic this or	은		ent 2 ER/Outpatien		4 ☐ Nursing Ho	me 5 🗆 Residen	ce 6 Other (Spec	cify)				
on of	ending F sath. or: After t the funer	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28c. Injury work' M 1 🗀		28d. Describe how	injury occurred					
Division of	pital or Attendi burs after death, eral Director: A filled in by the fi		3 Suicide 6 Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,				
	To the Hospital or Attending Physician: The law requires that the within 42 thours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of which could be considered as a constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant	amination and/or investi	gation, in my opinio	n, death occurred at	the time, date and I	place, and due to the	cause(s) and manner stated.				
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	nds	{	30 Name and address of person who completed cause of de	eath (Item 23a) (Type, Pr	rint) WM	RMI	1250	Dulie	ownstock				
	Stat Registra		31. Date filed (Month, Day, Year) FEB 2 4 2012	r's Signature	V. J		, , ,,,	VIDE					
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12-01466

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Stephen Todd Smith	State of Maryland / Department of Health a

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L.,	$\cup$	- 1	2	0	U	U	- 1	4

		1- For State Registrar		Certific	ate of	Death			Re	g. No.	201	2 0001	
Physici		Decedent's Name (First, Midd			•				Date of Deatl Month		Year	3. Time of Death	
Modical Exami	iner	Stephen To				41 O'1 T			Month ebruary 1			1141 hrs	
		4a. Facility Name (if not institution 174 Tilden Way	on, give street and number)			tb. City, Town, o Edgewater		Death			unty of Death e Arundel		
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Yes		24Hrs. 8	. Date of Birt			hplace (State or	
Director			1XM 2F	46	Yrs	Months Day		Min.			Foreig	n m	
		221-60-3663 Usual Residence of Decedent		40	113				June 10	, 190	5	MD	
any		10a. State 10b. County		10c. City, Town	or Locati	on						10d. Inside City Limits	
nd show	'n	MD Ann	e Arundel	Edgew	ater							1 X Yes 2 No	
Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen	of What Cour	ntry?	
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r deat	Fun		1 X Yes 2	No No		(99)						vhite	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	þ	3 Widowed 4 Dir 15. Decedent's Education (Spe	vorced If Yes, Give Year 98	4-198 /	Deceden	Yes 2 X No	specify: etion (Give k	ind of work	done	Spe 16b Kind	of Business/li		
2 hou "nat	Completed	Elementary/Secondary (0-12)				ost of working life				100. 140	o, Baomicoan		
136 thin 7 than	du		4	c	ompu	ter tech	nnicia	ın	federal governm			overnment	
5-00 led wit Hygien other	ខ្ញ	17. Father's Name (First, Middle	, Last)						(First, Middle, Maiden Surname)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	B	Carroll V. S							a Jean Stephens Rural Route Number, City or Town, State, Zip Code)				
is my	မ	19a. Informant's Name/Relations		111		, -						Zip Code)	
IOTE, MD 21215-0036 ges I and 2 should be filed within 72 hours after death with the Maryland to T Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified at once	The Ima Jean Smith (mother) 11221 Line Road Dela 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date of Disposition (Name of cemetery, Date of Disposition)										9940 ition - City or	Town State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	Carroll V. Smith  Description  The Ima Signature  T												
timent ment	4 Donation 5 Other Specify: Hebron Cemetery 2-25-201								2012	]	Hebron	, Maryland	
Baltimore, MI permit. Pages I and 2 s Department of Health as Important: If item 27 injury or other traum	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Short Funeral Home												
Physician		23a. Part I. Enter the disease, or	complicatio s that caused t	the death. Do n	ot enter th	E. Grov	7e Str , such as ca	rdiac or res	De L11 spiratory arre	nar, I	DE 19 or heart	940 Approximate Interval	
/Medical	8 6	failure. List only or ca se				1.	1	D4				Between Onset and Death	
£xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	quence of):	ic Ca	rdiovas	cular	Dise	ase				
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	<u>l</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consect c.	quence of):									
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BO)	Physician	1 Yes 2 No 9 Un	known 9 Unknown										
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Division tal or Attendi rs after death. al Director: A	Eat	2 Accident Inve	stigation 28e Place of Init	urv - At home fa	arm stree				Location (St	reet and N	lumber or Rur	al Route Number, City	
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Division of Vital Records, P.O. Box 68.  To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying P	hysician: To the best of my	knowledge, de	ath occurr	ed at the time, d	late and plac	e, and due	to the cause	(s) and ma	anner as state	d.	
o the ithin o the o the omplet	Medical	one) 2 Medical Exa	aminer: on the basis of exam	nination and/or i	nvestigati	on, in my opinior	n, death occ	urred at the	time, date a	nd place, a	and due to the	e cause(s)	
HSES	Me	29b. Signature and title of certific				29c. Licens						th, Day, Year)	
		- //				O.C.	M.E.			Februa	ry 20, 201	2	
OCME	Ì	30. Name and address of person				M 5 50	<u> </u>	D 1::					
	Mary G. Ripple/MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223												
St Regist	tate trar	31. Date filed (Month, Day Year)	2012 Registrar	s Signature	back								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cathey Teresa Smullen 1124 AM 2 20 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death RIGIONAL HICOMICO 6 Sex If Under 1 Year If Under 2 **Funeral** Age (In yrs. last birthday, 9. Birthplace (State or Foreign Months (Month, Day, Year) Hours **Director** 1 🗆 M 2 🔀 F 212-72-0699 55 Yrs 08/11/1956 Maryland Usual Residence of Dece shov 10a. State 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Wicomico Fruitland Yes 2 No 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral 23a 410 Clyde Ave. 21826 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner 14. Race - American Indian, Armed Force: Black, White, etc. ō 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Completed by 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Sales Retail traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rita Buhner Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Smullen/son 114 Priscilla St., Salisbury, MD 21804 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If ii any injury or c 1 X Surial 2 Cremation 3 Removal from State Wicomico Memorial Park Donation 5 ☐ Other (Specify) 2/25/2012 Salisbury, MD f Funeral Service 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Yal Pa /1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one aus on each line. Approximate Interval Between Onset and Death Im Jediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or s consequence of): if any, leading to immediate cause. Enter Underlying Exami that initiated events Due to (or as a consequence of): resulting in death) Last the burial attending physician for use as the buria Physician/Medical The law requires that the death certificate be 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed should peen : 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death? this certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No 1 Tes ျ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer. 28d. Describe how injury occurred 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) ITE and address of person who completed cause of death (Item 23a) (Type, Print) Lord Gi Sylheos

State Registrar Him

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 08377 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Sara Elizabeth Stouffer 10:45 PM March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumber land The Lions Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) Month, Day, Yea 4/25/27 214-22-5449 84 Director 1 □ M 2**X** F Vrs show 10a. State 10d. Inside City Limits at 10b. County 10c. City, Town or Location Director Cumber land notified MD Allegany 28a-f 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō ms 23a or must be r USA 21502 Funeral 801 Roeth Avenue an "natural", or items Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after Yes 2 **x** No If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Own home homemaker event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic even ပ Leora Hay Myron S. Berkley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Holland St., Cumberland, MD 21502 ant of Health a t: If item 27 is y or other trai Donna Dicken/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3/12^{Date} cemetery, crematory or other placel 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Flintstone, MD Rocky Cap Veteran Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ End 5 age
Due to (or as a const uence of): 2month End disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year signed by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe page 2 hours after death. Ineral Director: After this certificate 2 X N 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0055325 March 07, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishoplealsh Road, Cumberland, MD

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

MAR 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] | ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2012 1au <u>Clyde Lester Strite Jr</u> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rovenwood Lutheran Village Washington erstowr Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 □ F Days Hours Months Min 97 Dec. 9,1914 214-10-5137 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Wedical Examination cust be notified at 1 ☐Yes 2√ No Md. Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 19800 Tranquility Circle 21742 U.S.A Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Electrical Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Clyde Lester Strite Sr. Susan Sudie Minnick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 42 S. Tamarac Dr. Shepherdstown, WV. 25443 Larry A. Strite (Son) March 8, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Md. 22. Name and Address of Facility 12525 Bradbury Ave. 21. Signature of Funeral Service Licenses J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 Approximate Interval Between Onset and Death 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Me byo voscu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner lene 3 morles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2⊠No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shul- Hagstein 21740 HAPT. 32. Registrar's Signature 31. Date filed (Month. Day, Year) State MAR 1 6 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Martch 5, 2012 2:56 P.M Robert Gerald Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Smi thsburg Washington 12824 Unger Rd. . Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ★ M 2 □ F March 230, 1934 Maryland Director 217-30-5438 77 Usual Residence of Deceden 28a-f shov nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. Ordent: If item 27 is marked of other than "natural", or items 23a or 28a-f sho ortant: If item 27 is marked of other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 Yo Washington Smi thsburg МА 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 12824 Unger Rd. 21783 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Fabricator Sheet Metal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Abigail Elizabeth Trout Harry Chester Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Fales (Daughter) 11422 National Pike Clear Spring, Md. 21722 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or oth 20c. Location - City or Town, State March 8, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory Smithsburg, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave M01414 J.L. Davis Funeral Home Smithsburg Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final Onset and L Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): townor To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 2 No Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03/0 2019 007-24-6 6 gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mouhomad Bazzi M.D. 1130 Opal Ct. Hagerstown, Md. 21742 31. Date filed (Month, Day, Yea MAR 1 6 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore niv. of MD Medical lenter If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Min Sept 23 218-30-1832 78 **Director** Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 No Kent Galena ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 West Cross St. 21635 U.S.A. 12. Was Decedent Ever in U.S.

Armed Forces?

1 ★ Yes 2 No 1954

If Yes, Give
Year or Dates. -1957 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White "natural", Specify: Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer Power Tool Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, John Carvel Sutton, Sr. Elizabeth Adella Lusby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Sue Sutton (daughter) 8757 Orchard Dr. Chestertown, MD. 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Still Pond Cemetery 3/14/12 Still Pond, MD. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 M00510 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter art failure. List only one cause on each line terval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Due to (or as a consequence of): (eukemia Medical Examiner Folliadar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examir requires that the death certificate be executed Cown and C Due to (or as a consequence of g physician and s the burial-trans resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending after death.

Director: Aft d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Baltomore,

Greene

12-01836 John Shuron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 08381 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 4, 2012 **Medical Examiner** 1615 hrs John David Shuron 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 410 A Center Street Frederick Frederick 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Hours Min. Director Months Days 1 X M 1/7/1986 Country) VA. 2 F 212–15–8585 26 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at onernotified at once Frederick Brunswick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1048 Orndorff Court 21716 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 White, etc. 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Compl Ft. Detrick 12 Commissary 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Stephanie Dennise Shuron David Powell 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1048 Orndorff Court, Brunswick MD. 21716 Stephanie Powell, Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State or other 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 3/10/2012 Hagerstown Cremetory Hagerstown MD 4 Donation 5 Other Specify: Signature of Funeral Service Licer 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD 21716 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a Atrioventricular nodal artery dysplasia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial - transi sician/Medical X UNPENDED  $\square$  AMENDED 23a,27, per me, g927 5-16-12 sm Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Phy Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? É 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? Yes 2 No 1 Yes 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other A Nursing Home 5 Residence 6 🗸 Other Scene this 1 🗸 Yes After t 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: Director: 2 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 5, 2012 30 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cosby Minor Stokes, Jr. February 2012 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-30-8883 (Month, Day, Year April 25, Vear Months Davs Hours 76 **Director** 1 🛛 M 2 🗆 F 1935 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Anne Arundel Annapolis 1XXYes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 909 Van Buren Street with 23a 21403 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2XXIIo Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Painting Contractor Painting 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cosby Minor Stokes Esther Hall 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Van Buren Street Annapolis, Maryland Barbara Ann Stokes/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 2/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland Signature of the ral Service dicensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician. SWALL CELL WING CANZEN METTASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 as the l IF FEMALE nse 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy detached for in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
Funeral Director: After this certificate has b autopsy Yes 2 No 2 000 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျှ 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 0 201 death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ MARCH 6 2012 ear 7:37A M GORDON JAMES SELKIRK Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner CHARLES 4210 SOUTHWINDS PLACE WHITE PLAINS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 215-62-9345 Director 1 🕱 M 2 □ F 57 8-15-1954 WASH., D.C. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director CHARLES MD. WHITE PLAINS 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a 4210 SOUTHWINDS PLACE U.S.A. 20695 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ō by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: WHITE 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ELEVATOR MECHANIC LOCAL#10 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H WILLIAM GEORGE SELKIRK NORMA CORNELIUS ge 1 and 2 should b nt of Health and Mer :: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WHITE PLAINS,,D. 20695 DENISE SELKIRK-SPOUSE 4210 SOUTHWINDS PLACE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2  $\square$  Cremation 3  $\square$  Removal from State RESURRECTION CEMETERY 3-13-Department of Important: If any injury or 12 CLINTON, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 Signature of Funeral Service Licens 2 Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Metastatic Onset and Death Immediate Cause (Final brain Carcinoma Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 1 L Yes 2 L 9 L Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Sesidence 6 Other (Specify) 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending Division s after death.

I Director: Aff 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/12 3 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.R. N. JAYAN HAN 33, 28 Old WASH. Rel 20602 31. Date filed (Month, Day,

Registrar

5 2012

68760

Box (

of Vital

State of Maryland / Department of Health and Mental Hygiene 2012

1 - State Amend #20b 20c per fh 03 certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 23, 2012 1:35 Р м Carolyn Mary Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 1, 1944 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛂 F Months Days Hours Min Yrs DC **Director** May 578-58-0410 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No Maryland Prince George's Capital Heights 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7443 Shady Glenn Terrace 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc 6 þ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked off
any injury or other traumatic even
one. ပ္ Charles Lorenzo East Mary Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Madison Street NE Washington, DC Tisha Baylor Elliott - Daughter 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Lincoln Memorials, 3/6/121. Suitland, MD unk 4 ☐ Donation 5 ☐ Other (Specify) unk. 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 20019 4001 Benning Road NE Washington, DC Truval M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Fatal arruth disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): and I-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🐼 No the a Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Diabetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page To the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No ၉ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred After 12 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D0223390 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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	-	For State Registrar					tificate c				Reg. No. 2 (	012	08385
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Medic	al		RLES_	JERO		<b>T</b> )	4b. City, Tow		en of Death	FEBRUAF			1:17 A M
Examin			THERN M	IARYLAND H			CLINT	ON	der 24 Hrs.	8. Date of Birtl		CE GE	EORGE S
Funeral Director		577-48-5 Usual Residence	158	1 <b>X</b> M 2 □ F	76	Yrs.		ys Hour		DEC. 18		0	RTH CAROLINA
yland f shoved	ctor	10a. State	10b. County			y, Town or Lo	cation						10d. Inside City Limits
ne Mar or 28a- notifi	Director	MD 10e. Street and Nur		GEORGE'S	SUL	TLAND	10f. Zip Coo	le .			10g. Citizen of	What Cou	1 X Yes 2 No
with the	Funeral			RIVE #104			2074				USA	TTIAL COL	array.
be filed within 72 hours after death with the Maryland antal Hyglene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by	11. Marital Status  1  Never Marr 3  Widowed		12. Was Deced Armed Force 1 Yes, 2 If Yes, Give Year or Date	es? No <b>NA</b>	VY	Was Decedent of Yes, specify C	uban, Mexi	ican, Puerto	ecify Yes or No- Rican, etc.)		ck, White,	ican Indian, , etc. <b>.ACK</b>
hours matur dical E	olete		15. Decedent		25.		lent's Usual Ockind of work do		and of work	ina	16b. Kind of E	Business/Ir	ndustry
within 72 /giene. <b>ner than</b> '	• Completed	Elementary/Second		College (1-4	or 5+)		O NOT use reti		TOST OF WORK	ing	PRIVA'	TE	
permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.	To Be	17. Father's Name (	(First, Middle, La REDRICK	st)		_				e (First, Middle, I	Maiden Surnam	ne)	
should and M		19a. Informant's Na								al Route Number,			
of Health of Health fitem 27 rother tr		ERIK TE 20a. Method of Disp	ERRY/SON position	Y	20b. P	lace of Dispo	sition (Name o		1	4 SULTLA 66te 2012	20c. Location		ND 20746  Town, State
Page 1 ment of ant: If it ury or o			☐ Cremation 5 ☐ Other (Sp.	3 ☐ Removal from S ecify)	tate U/	emetery, cren K <b>Harm</b>	ony Cer	_{place)} netery			<del>J/K</del> Lan		
permit. Page Department of Important: If any injury or once.		21. Signature of Fu	neral Service Lic	censee N. Cジカ	nolin								HOME, INC. AND 20785
a right	al Examiner	23a. Part 1. End 1 shock, or Hea Immediate Cause Immediate Cause disease or condition resulting in death)  Sequentially list confirmed in the cause. Enter Unde Cause (Disease or that initiated event resulting in death)	(Final on on on on on on on on on on on on on	b. Due to (or	used the death	estive yence of):  V + en  uence of):			as cardiac				Approximate Interval Between Onset and Death
or Attending Physician: The law requires that the death certificate be after death.  Director: After this certificate has been signed by the attending physicis in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2 9  Unknown	months? ☐ No		irth 2 🗀 Feta ant at time of c	al death 3 🗌	Ectopic pregi					ate of deliventh	very Day Year
requires that the been signed by should be detail	b S	Part II. <b>Other signi</b> i	ficant condition	ns contributing to dea	ath but not res	ulting in the u	nderlying caus	e given in P	art I.		bacco use cont		the cause of death?
The law re ate has be page 2 sh	Completed									24a. Was a autop perfor 1 \(\sum \) Yes	sy med?	prior to co death?	opsy findings available ompletion of cause of
Physician: The this certificate ral director, pag	Be	25. Was case referrexaminer?		Hospital:				i. Place of D	Death (Chec	k only one)	_		
ding Phys h. After this funeral di	cate: To	1 Yes 2	5 Pending	28a. Date of	injury Day, Year)	ER/Outpatier 28b. Time of injury	28c. I	ijury at vork? ☐ Yes 2		ome 5 Residence 28d. Describe ho			
l or Atten after deat Director: d in by the	Certificate:	3 Suicide 4 Homicide	6 Could n	ot be 28e. Place o	f Injury - At ho , etc. <i>(Specify</i>	ome, farm, stre	eet, factory, off			28f. Location (Si City or Town		er or Rura	al Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check 2	Medical Ex	Physician: To the best aminer: On the basis Nurse Practitioner: 1	of examination	n and/or invest	igation, in my o	oinion, death	h occurred a	t the time, date ar	nd place, and du	ie to the ca	ause(s) and manner stated.
To the within To the comp		29b. Signature and					29c. Lic	ense numbe	er		29d. Date signe		
9		30. Name and addr	ess of person w	ho completed cause	of death (Item	1 23a) (Type, P	(rint) (03 S)	mal	H-57	1205	uiton	M	1 20735
Stat Registra		31. Date filed (Mont	th, Day, Year)	32. Reg	gistrar's Signat	ture							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First. Middle. Last) 2. Date of Death 3. Time of Death ^{Day} 2012 March 5. Physician/ Walter Wallace Tapscott 9:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 215-62-5473 1 **X** M 2 □ F 59 11/07/1952 Washington, DC 28a-f show 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No St. Mary's Charlotte Hall 5 10a, Citizen of What Country? 23a Funeral CHVH, 29449 Charlotte Hall Road USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 1 Yes 2 No
If Yes, Give 1 X Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic 11th Construction marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Leon Tapscott Rose Elizabeth Reardon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Rose E. Day / Mother 227 Meadow Trail, Highland Heights, KY 41076 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Maryland Veteran Cem 03/13/2012 4 Donation 5 Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Funeral 9 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 #M00817 23a. Part 1. Enter the disease, or competications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Yes 2 No 1 ☐ Yes 2 ☐ Unknown g Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MUAS CULAR ACCIDENT 1 Yes 2 No 3 Probably 4 Unknown es porof is Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural injury 5 Pending Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

21215-0036

Baltimore, Maryland

68760

Box

P.O.

Records,

of Vital

Division

Registrar

cause of death (Item 23a) (Type, Print)

29449 (44,2016TTGHALLED 20622

State Registrar Edward R.

Stankiewicz, MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD-039657-6

1579 Chichester Ave., Linwood, PA 19061

		Pleas	se Type or Pri							-		
		For State Registrar	State of M	-		nent of F cate of D		Mental Hy	/giene Reg. No	2012	08388	
Physicia Medic		Decedent's Name (First, Middle, SHIRLEY RAY ST	,	DAWAY				2. Date of D		2 <b>01</b> 2	3. Time of Death 03:15 RM	
Examin		4a. Facility Name (if not institution, g			City, Town, or	Location of Death	n	4c	. County of Death			
Funeral Director		5. Social Security Number  226-36-6787  6. Sex 1								9. Birthplace (State or Forei Country) VIRGINIA		
yland -f show ed at	ctor	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	n				11	Dd. Inside City Limits 1 ☐ Yes 2 🛂 No	
tth with the Maryland ms 23a or 28a-f show must be notified at	al Director	MARYLAND CEC 10e. Street and Number	<u>IL</u>	R	ISING	of. Zip Code			10g. Ci	tizen of What Coun		
des rite	y Funeral	207 EBENEZER C	12. Was Decedent E Armed Forces?		13. Was E	219 Decedent of Hi , specify Cuba	11 spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No o Rican, etc.)		TED STATE  14. Race - America Black, White, e	an Indian,	
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nd 2 should be salth and Men m 27 is marke ler traumatic		19a. Informant's Name/Relationship JAMIE RAY STALLI			_					r Town, State, Zip C MARYLAND		
permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition  1 ☐ Burial 2 ▼ Cremation 3 4 ☐ Dopartion 5 ☐ Other (So	B ☐ Removal from State		y, cremator	(Name of y or other place CREMATO		PARY 2012		ocation - City or To		
permit. Departimport any inj		21. Signature of Furnital Service Inc	ensee							HOME, P. EAST,MARY	A. LAND 21901	
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Examiner	<u>.</u>	Sequentially list conditions,	b. —	A T H	,-	SCLE	Rosis			Difere		
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cate be exe physician a s the burial-	_	resulting in death) Last	d.	a consequence o	··).							
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian.	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		opic pregnanc er (specify)	у			23d. Date of delive Month	ry Day Year	
requires that the de been signed by the should be detached	ed by Pł	Part II. Other significant condition	s contributing to death b	ut not resulting in	n the underl	ying cause giv	en in Part I.			use contribute to the	e cause of death?	
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Attendin ar death. ector: Aft by the fur	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could not 4 Homicide determin	ation ot be 28e, Place of Inju	ıry - At home, far	N		Yes 2 No			d Number or Rural	Route Number,	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After thi completed filled in by the funeral		29a. Certifier 1 ☐ Certifying F	Physician: To the best of	my knowledge, o					ause(s) ar	nd manner as stated		
the Ho hin 24 t the Fui npletec	Medical	(Check 2 Medical Extonly one) 3 Certifying N	aminer: On the basis of early and the large Practioner: To the	xamination and/or	investigation	on, in my opinio occurred at the	n, death occurred time, date and pla	at the time, date	and place	e, and due to the cau	se(s) and manner stated	
To with		29b. Signature and title of certifier	mit	5 M	Δ_	29c. License	number 3 8 2 5		29d. Da	te signed (Month, E	*	

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PREM MITTAGE MY, VAMIHCS, * PERRY POINT, MB. 21902

31. Date filed (Month, Day, Year) ... 32. Registrar's Signature

02/08/20/TEB 13 2012 August B. Aparlal

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mildred Elwilda Turley 10:00 P M 2012 February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LaVale Allegany 505 Braddock Street 8. Date of Birth (Month, Day, Year) 05/27/1912 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1 □ M 2 💢 F West Virginia 99 Director 215-26-9627 Usual Residence of Decedent show 10h County at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Examiner must be notified 28a-f 1 Yes 2 X No Allegany LaVale 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21502 505 Braddock Street items Page 1 and 2 should be filed within 72 hours after death v 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 5 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify "natural", 3 X Widowed 4 Divorced White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Puffinburger Eva Elizabeth Graybel Montary of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Maryland Street, LaVale, MD 21502 Vickie L. Crowe / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/29/2012 Cumberland, MD Hillcrest Mem. Park In ture of Funeral Se 22. Name and Address of Facility Alams Family Funeral Nome, 404 Decatur Street, Cumberland, MD 23a. Part Neater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U deflying Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be P.O. Box 68760 ass 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 Yes 2-No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 N 2 No Yes hours after death. Ineral Director: After this certifica of filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Yes 2 - 100 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 - Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi February 27, 2012 D17565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MS 922 National Highway, LaVale, MD Anthony J. Bollino, Jr., M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEBZI Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

orogg Otaan Th		1- For Stata Registrar	Cei	rtificate of De			eg. No. 201	2 0839
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last	) Stuart	Trexler		2. Date of Dea Month March 3, 2	th	3. Time of Death 1005 hrs
parties (		4a. Facility Name (if not institution, give		4b. C	ity, Town, or Location of	f Death	4c. County of Death	
Funeral		5. Social Security Number 6. Sec		ast birthday) If	Under 1 Year If Under onths Days Hours	1.0	th(MM/DD/YYYY) 9. Bird	hplace (State or Maryland
Director		171-38-6574 1X	M 2∏F 65	Yrs.	ontris Days Hours	10/03/	/1946 Co	untry)
and I show any	or	10a. State 10b. County MD Alle	10c. City, egany	Town or Location Cumb	erland			10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once,	Director	10e. Street and Number 1825 Bedford Str	eet	10f	Zip Code 2150		0g. Citizen of What Cour USA	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No if Yes, Give Year	If Yes, s	cedent of Hispanic Original pecify Cuban, Mexican, $2 \begin{bmatrix} X \end{bmatrix}  \text{No}  \text{specify:}$		- 14. Race - Ameri White, etc. Specify: White	
hours aft natural' Examin	ed by	15. Decedent's Education (Specify on	or Dates: ly highest grade completed)	16a. Decedent's Us	sual Occupation (Give ki working life, DO NOT u		16b. Kind of Business/li	
1036 vithin 72 ene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Engi	neer		Tire and Ru	ıbber
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Karol Orgin	Trexl	er	18.Mother's He]	s Name (First, Middle, M Len	Maiden Surname) Augusta N	Merrick
MD 21 d 2 should Ith and Me n 27 is ma	ဥ	19a. Informant's Name/Relationship (Ty Jeanne V. Trexler	pe,Print) ?/Wife	19b. Mailing Add 1825 Be	ress (Street and Numb dford Stree	et, Cumberl	nber, City or Town, State Land, MD 2	Zip Code) 1502
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Pamoval from State	Place of Disposition crematory or other pluber land C	ace)	Date 03/04/2012	20c. Location - City or Cumberlar	,
Balti permit. Departu Import		21 Sgnature of Funeral Service Lice	ee				lly Funeral perland, MD	Home, F.A. 21502
Physician Madical		23a. Part I. Enter the disease, or complifatione. List only one cause on each	ch line.		ode of dying, such as ca	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner			ntraoral Gunshot Wour  Oue to (or as a consequence of					- Dodan
	iner	cause. Enter Underlying Cause	Oue to (or as a consequence of	f):				
nted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of	f):				
D, be exect sician an ourial - tr	Medical	UNPENDED	AMENDED					
Records, P.O. Box 68760,  The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burnal - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of dea	2 Fetal de		pregnancy	23d. Date of delivery Month D	ay Year
p.O. Bo that the deat ned by the at detached for		1 Yes 2 No 9 Unknown  Part II. Other significant conditions	9 Unknown  contributing to death but not re	esulting in the underl	ying cause given in Part	t I. 23e. Did to	bacco use contribute to t	he cause of death?
rds, P.O. requires that the been signed by a hould be detached	ted by					1 Yes	No 3 Prob	ably 4 Unknown opsy findings available
Records, The law requirent that has been a page 2 should	Completed					autop perfor	sy prior to comed? death?	ompletion of cause of
Vital Rec ysician: The l his certificate l	8	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (C	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Residence 6 🗸 Other:	Scene
n of Vid ding Physic a. After this funeral dire	on: To	1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injury FOUND:	28c. Injury at Work?	28d. Describe h	now injury occurred	
Division of Vital Records, tal or Attending Physician: The law requir is after death.  To Director: After this certificate has been seen in the funeral director, page 2 should it.	Certification:	2 Accident Investigation 3 Suicide 6 Could not b	n Mar 3, 2012	0955 hrs ome, farm, street, fac		. 28f. Location (S or Town, S	Street and Number or Rur tate) Street, Cumberland, I	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical Ce	29a. Certifier (Check only one) 2 Medical Examinar:	n: To the best of my knowledg			ce, and due to the caus	e(s) and manner as state	d.
7 5 5 5 6 5 6 5 6 5 6 5 6 5 6 5 6 5 6 5	Me	29b. Signature and title of certifier	and manner stated		29c. License number		29d. Date signed (Mon	th, Day, Year)
)2.01		30. Name and address of person who co	ompleted cause of death (Item	23a)	O.C.M.E.		March 4, 2012	
nes	ate	Ana Rubio MD. Assistan  31. Date filed (Month, Day, Year)	t Medical Examiner 9		e Street, Baltimore	e, MD 21223		
Regist		MAR 0 5 2012	A	backet				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle 1 ast) 2. Date of Death 3. Time of Death Physician/ Matthew Trafton Jamison Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HICOMICO If Under 9. Birthplace (State or Foreign Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** Min n a 1 🛛 M 2 🗆 F **Director** 3 9 02-22-206 Mary land Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Maryland Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30290 Fooks Lane 21871 USA death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc 9 þ 1 Yes 2 X No If Yes, Give Year or Dates. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: Black "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) n|a n a n|a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F. ပ Lameka T. Collins James M. Trafton Department of Health and Important: If item 27 is m any injury or other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lameka Collins/mother PO Box 254, Westover, MD 21871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/24/2012 Westover, MD Church Cemetery 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 XNO X Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 No မ 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify the Funeral Director: After this mpletely filled in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 3 Suicide iniurv 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

. Date filed (Mon

Mollis

Phillip

Registrar's Signature

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Veal 5:12 PM HARLES R. TAYLOR 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Wicomico Salisbur Coasta Hospice the at Social Security Numbe Year If Under 24 Hzs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director 1 X M 2 🗆 F 11-8-1930 MD or 28a-f shov 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🗷 No MD TYASKIN WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 22853 21865 OSA 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 1948
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced 1957 Specify: WHITE Year or Dates Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. SEA FOOD ATELMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EN LATMORE permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA TRYLER WIFE 20a. Method of Disposition MUDDY HOLE RD TYASKIN, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State AlkRury Crematery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee any Compensel in BIVALUE MID 21814 23a. Part Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final MALIGNAN Onset and Death Ph sician/ LUNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed death? Yes 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) HOSPIER Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 141 Natural 5  $\square$  Pending work? injury Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c License num
000 5 84(0 and title of certifier 29b. Signatur and address of person who completed cause of death (Item 23a) (Type, Print) 733 SACIBBY 1500 vous 31. Date filed (Month, Day, 32. Registrar's State 27 2012 Registrar

12-01954 Holland Taylor

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ioliana Taylor		1- For State Crivial yiand / Department of Health and Wentai Fig. Certificate of Death		Reg. No.							
Physicia	an/	Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death						
Medical Exami		Holland Aneurin Taylor	Month March 8,	2012 4c. County of Dea	0612 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5120 Wolfe Drive Hughesville		Charles	ui						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	_	irth(MM/DD/YYYY) 9. B							
Director		216-19-8321 1XM 2 F 24 Yrs. Months Days Hours Min. 06/12/1987 Foreign Country) Maryland									
v any	İ	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
land f show	5	Maryland Charles Hughesville			1 Yes 2 No						
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?						
hours after death with the Maryland natural", nr items 23a or 28a-f shr Examiner must be notified at once		5120 Wolfe Drive 20637  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or N	U S A lo- 14. Race - Ame	erican Indian, Black,						
r death v nr item must b	Funeral	1 X Never Married 2 Married Armed Forces?  If Yes, specify Cuban, Mexican, Puerto		White, etc.							
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D36 thin 72 then edical	Completed	1 Assistant Project Ma	nager	Constr	uction						
21215-0036 wild be filed within 7 Mental Hygiene. marked other then c event, the Medica				Maiden Surname)							
121 Id be fi Aental cocent,	Be G	Steven James Taylor Lois Mi  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F			te Zin Code)						
MD 2 shou lith and N 127 is in numatic	٩	Steven J. Taylor/Father 5120 Wolfe Drive, Hu									
G, R l and Health Fitem	ı	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State						
Pages nent of nut: It		4 Donation 5 Other Specify: Brinsfield-EcholsCrem. 03/	10/2012	2 Charlotte	Hall, MD						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	ı	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bri									
Physician	-	$M00817 \mid 30195$ Three Notch 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			Approximate Interval						
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a Narcotic Intoxication			Between Onset and Death						
Examiner		or condition resulting in death)  Due to (or as a consequence of):		-							
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	Examine	cause. Enter Underlying Cause									
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760, cate be physici the buri	/Mec			23d. Date of delive							
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Box 6876 re death certificat r the attending phred for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown									
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Division of Vital Records, rater death.  The law requirers after death.  The brector: After this certificate has been sited in by the funeral director, page 2 should be the funeral director.	Completed		24a. Was		autopsy findings available completion of cause of						
Recol The law cate has	dmo		perf	formed? death?							
of Vital Recing Physician: The After this certificate There and director, page	BeC	25. Was case referred to medical 26.Place of Death (Check examiner?	only one)								
n of Vital   ding Physician: h. After this certifi	일	1 Yes 2 No No Inpatient 2 ER/Outpatient 3 DOA Outel 4 Nursin		Residence 6  Oth	er: Scene						
oding 1	io io	1 Natural 6 D n ii (Month, Day, Year)	unknov	• •							
r Attender death	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City						
Div	Certification:	Suicide 6 Could not be determined (Specify) Found: Residence		State) 5120 Wolsville, MD.	ie Dr.						
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a									
To To con	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (M	onth, Day, Year)						
		O.C.M.E.		March 9, 2012	_						
		30. Name and address of person who completed cause of death (Item 23a)	222								
		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21	223								
S1 Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature									

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State		Sta	ate of	Maryla	nd / De	partmer e <i>rtificat</i>	nt of H	ealth a	and M	lental Hy			)   2	08	394
		Registrar  1. Decedent's Nam	CHINCAL	0, 0	Catif		Reg. No.  2. Date of Death				3. Time of	Death					
Physicia Medic		Dorothy	Ward Th	nompso	n							Month 2	/25/	2012	Year	6:22	Рм
Examin		4a. Facility Name (li <b>Hartley</b>							4b. City, Town, or Location of Death Pocomoke City				4c. County of Death Worcest			er	
Funeral Director		5. Social Security N 213-05-2		6. Sex 1 \( \text{M} \) 2	<b>X</b> F 7	'. Age (In yrs.	last birthday Yrs.	/) If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of B			9. Birthp Count	lace (State o	r Foreign
MC T		Usual Residence of				140.0											
aryland a-f sh fied a	Director	10a. State	10b. County Worcest	or		- 1	comoke								1	0d. Inside Ci	2 No
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with t	Funeral	1006 Mark	ket St.					218	351				US			,	
death items ner m		11. Marital Status		Arr	med Forc	ent Ever in U	J.S. 13					cify Yes or No Rican, etc.)	)~		ce - America		
after Il", or xamil	d by	1 ☐ Never Man 3 <b>X</b> Widowed		ed 1 [	Yes 2 Yes, Give	2 <b>X</b> No		1 🗆 Yes				, ,			· Whit		
hours natura ical E	Completed		15. Decedent	's Education		es.		cedent's Usu					16b.		Business Inc		
in 72 e. nan "r	duc	(Spe	ec <i>ify</i> on <i>ly high</i> es conday (0-12)	1	<i>ipleted)</i> llege (1-4	1 or 5+)	Ìife.	e kind of wo DO NOT use		ıring most	t of worki	ng				ĺ	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's N			nt)			_				Route Numb					
ige 1 and nt of Hez t: If item r or othe		20a. Method of Dis 1 X Burial 2	position  Cremation	3 ☐ Remov	al from S	State	Place of Dis	position (Nar rematory or o	ne of other place	)	- [	Date	20c. l	_ocation	- City or To	wn, State	`
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permit Depar Impor any in		Muil	Les 1	10	ka	CFS						moke C					
Physician/ Medical		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List or (Final	lly one caus	e on eacl	h line.	ary	Α.	1		-	r respiratory a	- 2			Approximat Interval Bet Onset and I	ween
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uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):															
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To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending placemental Director. After this certificate has been signed by the attending placempleted filled in by the funeral director, page 2 should be detached for use as to completed filled in by the funeral director, page 2.	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2  9  Unknown	months? ☐ No	1 [[] 4 [[]	Live B	ome of pregr irth 2  Fe ant at time o	etal death 3	B		,					ate of delive	•	'ear
requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											co use contribute to the cause of death?				
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The law i ate has t page 2 s	Completed											per	opsy formed?	,	prior to cor death?	npletion of c	ause of
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Physic this c	: <b>1</b> 0	1 Yes 2,	No		1 Ir a. Date of	•	ER/Outpat	tient 3 D		4 🛂 Nu		me 5 Res				_	
eath. or: After the funer	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investig	ation	(Month	, Day, Year)	injury		28c. Injury at work?  M 28d. Describe how injury occurred								
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the funer		4 Homicide	determi			of Injury - At I g, etc. <i>(Speci</i>		street, factor	y, office			28f. Location City or To			er or Rural	Route Numb	er,
he Hospi in 24 hou he Funer ipleted fil	Medical	(Check 2		aminer: On	the basis	of examinati	ion and/or inv	estigation, in	my opinior	n, death oc	curred at	d due to the o the time, date e, and due to t	and plac	e, and du	ue to the cau	ise(s) and ma	nner stated.
To t with To t		29b. Signature and	In Spr	AD A	2, 1	BARA	H.	290	License	number	22				25 -	Day, Year) -201	2
ET	Ca	30. Name and add	ress of person w	ho complete	ed cause	of death (Ite	em 28a) (Type	e, Print)	ke,	- a	10)	2/8	25/	ı			
Stat	te	31. Date filed (Mon	FEB 2	9 2012	32. R	gistrar's Sign		bark	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. 1.2

			1 - For State Registrar	State of Maryla		artment of F		Re	g. No.				
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death					
	/Medic		REUBEN THOMAS, JR.  4a_Eacility.Name_III not institution_cive.s			4b. City, Town, o	r Location of Dea	FEBRUARY	26, 2012 4c. County of Deal	12:35 A ^M			
1	Examir	ie(	*BRADFORD OAKS NURS	SING CENTER		CLINTON			-	PRINCE GEORGES			
	Funeral Director		422-42-1133	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) Co	hplace (State or Foreign unitry) ABAMA			
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits			
	Man, e-f sh iffed	tor	MD CHARLES	W	ALDORF					1 Yes 2 □ No			
	ith the	Director	10e. Street and Number			10f. Zip Code			og. Citizen of What Co	*			
	s 23e	eral	2003 WINGATE COUR	T #6 12. Was Decedent Ever in I	10 12	2060			14. Race - Ame				
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other then "neturel", or items 23e or 28e-1 show other treumetic event, the Medical Exament must be notified at	by Funeral	11. Marital Status  1 X Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🙀 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, Whit				
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occup	ation during most of we	orkina 1	16b. Kind of Business	Industry			
121	within ne. <b>hen</b>	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)		TRANSPORTA	PTATTON			
d 21	filed within Hygiene. other then ent, I've M		9 17. Father's Name (First, Middle, Last)		TRU	JCK DRIVE		ame (First, Middle, M		IIION			
ılan	should be find Mental branked of	To Be	REUBEN ALEXANDER T	HOMAS			UNKNO		,				
Maryland	d 2 sho h and l 7 Is me treume		19a. Informant's Name/Relationship (Type	. = '					City or Town, State,				
	of Health item 27 other tr		RUBIN THOMAS, III/ 20a. Method of Disposition		Place of Dispo	sition (Name of	!		LS, MARYLA 20c. Location - City or				
Baltimore,	eg = 10		1 X Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory`or other plac MEMORIAL		H 2, 2012	WALDORF,	MARYLAND			
alti	permit. Pag Department Importent: I any Injury o		21. Signature of Fuoeral Service License	2-2>									
<u> </u>	89 2 2		PLYDIA C. THORNION J	OHNSON MOO583					N HEAD, MI				
	Pnysician /Medical		23a. Part1. Enter the disease, or compliant shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	CANO		ng, such as cardia	ac or respiratory arre	st,	Approximate Interval Between Onset and Death			
	Examiner			Due to (or as a conse	quence or):								
	sit sit	iner	iner	iner	iner	if any, leading to immediate Due to (or as a consequence of):  Cause. Enter Underlying							
	ate be executed obysician and the burial-transit	xam	that initiated events resulting in death) Last	Due to (or as a conse	quence of):								
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9	tifficat ng phy as th												
.O. Box	at the death certific by the attending p tached for use as it	Physician/Med	ysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3[	Ectopic pregnancy Other (specify)	′		23d. Date of delivery Month Day Year			
<u>α</u>	res that thigned by	by Pr	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.										
ecords,	w require been sig should b				1 <b>☆</b> Ye	s 2□No 3□Pr	2 No 3 Probably 4 Unknown						
$\mathbf{\alpha}$	The lar ate has page 2	Completed						24a. Was an autopsy perform 1 Yes 2	y prior to	utopsy findings available completion of cause of			
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	Jeno	Cth	or 45	eath (Check only one		-4.			
of		-	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	IL 3 DOA	4 Nursing	28d. Describe ho	nce 6 Other (Spe w injury occurred	city)			
ion	토술 등 밝	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	Injury		1k? Yes 2 □ No							
Division	i Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, sti ify)	eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	nician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	ce, and due to the ca curred at the lime, da	use(s) and manner as ite and place, and due	s stated. a to the cause(s)			
	To the within Fo the comple	Me	29b. Signature and title of certifier	- James States		29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)			
	n		Wellen 110	Ime in		D0035	206	FE	BRUARY 26,	2012			
(	30,0		30. Name and address of person who co	ANNOR MO	11701	Livingston	Road		ungton, na				
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 9 201	2 32/Registrar's Sign	ature &	who							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Margaret Henrietta Turner February 11:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12001 Old Columbia Pike #702 Silver Spring Montgomery 8. Date of Birth (Month Day, Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Hours T929 New York Director 82 113-22-0881 Aug. Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 12001 Old Columbia Pike #702 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No 72 hours after 1 Yes 2XXNo Specify: If Yes, Give Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Administrative Assistant Howard Univ. Hospital marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary E. Edwards per it. Page 1 and 2 should ce Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Henry B. Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 75 Stringham Rd. #13 Battle Creek, Michigan 49037 Robin Roberts/Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 03/03/2012 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23 Par 1. Enter the disease, momplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Kidney Failure</u> Medical Due to (or as a consequence of Examiner Hypertension Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year 2 No 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TOBACCO USE Completed 1 x Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2X No မ 1 Inpatient 2 ER/Outpatient 3 I within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/28/2012 MD30151 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward Morris MD 106 Irving Street NW Washington,DC 20010 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

21215-0036

Maryland

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bukhsana February 1:00 AM 1 ab a 5 5 6 2012 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6150 SPRING PRINCE TERRACE GREENBEL If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) **Director** 49 PAKISTAN 28a-f shov must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director GREENBELT 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20770 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. Specify: ASIAN 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1:4 or 5+) OWN HOME HOME other traumatic event, Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ၉ HAKIM KHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a
Important: If item 27 is
any injury or SPRING GREENBELT MD. 20770 6150 IER. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

AMAA CEMETER: 1 Burial 2 Cremation 3 Removal from State 128/12 STAFFORD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL HC #1070 -22191 ST. WOODB 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatio disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Little Uniterlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 attending physi IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown the g Unknown P.O. signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 2 No 1 Tes Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral Natural 5 Pending work' 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. who completed cause of death (Item 23a) (Type, Print) 9200 Basil Ct. Ste200 exmolds State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29, FEBRUARY 2012 4:42 A M VANSANT LOIS MESSICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT 31744 JIM DAVIS ROAD **GALENA** If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 🗆 M 2 🗶 F Months 02/27/1927 Yrs PENNSYLVANIA **Director** 214-46-4806 85 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No MD KENT GALENA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral UNITED STATES 21635 31744 JIM DAVIS ROAD items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0 ð 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 Tes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the OWN HOME 12 HOMEMAKER Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LEVIN GALE MESSICK MARY DWYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2951 MT. AIRE LANE CHARLOTTESVILLE, VA 22901 SUSAN SMITH / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State CHESTER CEMETERY 03/03/2012 CHESTERTOWN, MARYLAND 4 Donation 5 Other (Specify) 21. Signatur of uneral Service License FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, 370 W. CYPRESS ST. MILLINGTON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only on call on each line Approximate Interval Between Set and Death Immediate Cause (Final Physician/ Mon disease or condition ) Medical resulting in death) **Examiner** que itially flet our altic Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No 9 Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perforn 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa ure and title of certified 29d. Date signed (Month, Day, Year) 6 d cause of death (Item 23a) (Type, Print) own ms a 31. Date filed (Month, Day, Year) State MAR -5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0039 <u>Rhoda C. Vernon</u> 02 701Z Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City. Town, or Location of Death 4c. County of Death MediCAL Alcomica ROGIONAL 3AL13bH14 If Under Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 1 🗌 M 2 🕱 F 215-30-5122 84 09/03/1927 Usual Residence of Deceden VA 28a-f shov 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Worcester Berlir 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1 Meadow Street 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed and Mental Hygiene.
Is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Secondary (0-12) College (1-4 or 5+) 12 MD Toll Facilities Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If Item 27 is marked any injury or other traumatin cone. 2 Blaine Carter Elizabeth McCallister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Vernon - son 10603 Wyld Drive, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brookview Cemetery 02/18/2012 Rising Sun, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, PA Edural Mckeston 111 S. Queen Street, Rising Sun, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Shock Ph_sician/ disease or condition Medical resulting in death) Due to (r as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year , the a thed for 9 Unknown should be detacl signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🕱 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 🗌 No Investigation Could not be Accident filled in by the within 24 hours after deal To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

ARROLL ST., SALISBURY,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

LSMAN ZULFIOAR 100 E · C

32. Regietrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death A Louis Patrick VanMeter Physician/ Morch 3:05 Medical Facility Name (if not institution, give street and number)
Meritus Medical Center 4c. County of Death Washington 4b. City, Town, or Location of Death Hage 15 town **Examiner** Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-54-1654 1**X** M 2 □ F 61 Director Maryland Oct. 8,1950 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director Hagerstown Md. Washington 1 Yes 2 No 10e, Street and Number 10g. Citizen of What Country? 21740 Funeral 204 N. Potomac St. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 18b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Tannery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Liladean May Emerson ပ Jack Louis VanMeter other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Mt. Carmel Church Rd. Keedysville, Md. 21756 item 27 John P. VanMeter (Son) Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Marchate 7, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg, Md. 2012 Signature of Funeral Service Licensee 12525 Bradbury Ave. 22, Name and Address of Facility J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Preumothora Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: The law requires that the death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obstructive pulmonary disease 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Leader 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12916 Conomar Drive, Suite 204, Hagerstown, Maryland 21742 THEODORU, MI) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

1 6 2012

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 2012 1 - State #26,30, TCHD, MD, 2/24/12 Certificate of Death r1s Amended Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 2012 3:25PM HELENE VAN VOORHIS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death TALBOT TALBOT HOSPICE HOUSE EASTON If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** GERMANY 1 M 2 XF Days Min JANUARY 05 1929 Yrs Director 097-28-7754 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Ves 2 No EASTON MARYLAND TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA / GERMANY 29773 DUSTIN AVENUE 21601 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. à 1 Never Married 2 X Married Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. NURSING ASSISTANT NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AMALIE BEISSWENGER ALDOLF DOMHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Page 1 and 2 CANDICE J. WOLFE GRANDDAUGHTER 1139 WHITE SANDS DRIVE LUSBY, MARYLAND 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN MEMORIAL PARK 2/24/2012 EASTON, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 21. Signature of Funds Service Licens 23a. Part 1. Enter the disease, or complication, the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final cancer Physician/ Lung disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as SP 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Year Month Day 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No or Attending Physician: 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? 2 **N**0 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Division 24 hours after death. Funeral Director: A Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріне Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D47311 2/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 51 MD 21619 Syranne Niemela, MD 30 Chester 101 RSID 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Theodore Spencer Williams 2012 February 11:30 p 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice - Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 118-12-4221 1 XM 2 - F 90 May 16, 1921 NY Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Montgomery 1 Yes 2 V No Silver Spring 10e. Street and Numbe 10g, Citizen of What Country? 15211 Elkridge Way, Unit 1J 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give 1942 Year or Dates. 1946 1 Yes 2 No Specify. 3 V Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Musician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Williams Annie Frieburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Williams / Daughter 4511 Grendel Road, Greensboro, NC 27410 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Funeral Service Lice 500 University Blvd. W Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Ph. sician/ Medical **Examiner** Examine

Physician/

Medical

10a. State

MD

**Examiner** 

**Funeral** 

Director

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items 23a or ner must be n

ed other than "natural", or iter event, the Medical Examiner

I Hygiene.

should be filed with and Mental Hygien is marked other th

permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev

Director

Funeral

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Completed

Be

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with the Maryland

72 hours after death

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician s the burial Medical Certificate: To Be Completed by Physician/Medical signed by the after death. filled in by the

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition  Myelodysplastic Syndrome								
resulting in death)	Due to (or as a consec	uence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution o							
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1  Live Birth 2 Fet 4  Pregnant at time of 9  Unknown	al death 3 🗌 Ectop	ic pregnancy (specify)		_	23d. Date of de Month	elivery Day	Year
Part II. Other significant conditions of Coronary Artery I		sulting in the underlyin	ng cause given in Part I.			use contribute to		
Aspiration Pneumo				pe	as an topsy rformed? s 2 XN	death?	itopsy finding completion o	gs available of cause of
25. Was case referred to medical examiner?			26. Place of Death (Che					
1 ☐ Yes 2X No	Hospital: 1  Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Re	sidence 6	Other (Spec	:ify) Hosj	pice
27. Manner of Death  1 Anatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not by		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe				
4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact	ory, office		(Street an own, State	d Number or Ru )	ral Route Nu	mber,
(Check 2 \( \subseteq Medical Exami	sician: To the best of my knowner: On the basis of examinations of examinations of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the bes	n and/or investigation,	in my opinion, death occurred	at the time, date	e and place	and due to the	cause(s) and I	manner stated
29b. Signature and title of certifier	7.	2	9c. License number		29d. Da	te signed (Monti	h, Day, Year)	
1 AXTHAN	Mill 98	CRNP	R143201			2/281	12	

Registrar DHMH 17 Rev 06-2011

State

within 24 hours a

To the Funeral E

completely filled

10+1

1355 Piccard Drive, Rockville, MD

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #100

Debrah Miller, CRNP

31. Date filed (Month, Pay Year) 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 28, 2012 11:15 PM Flovd. Lee Weber, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Medstar Montgomery Medical Center 01ney Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Month: 101-22-9938 Director 1**XX**M 2 □ F March 16, 1927 NY Usual Residence of Deceden 28a-f show with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3200 N. Leisure World Blvd., #220 20906 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give 1951–53 Year or Dates. 1 Yes 2 XNo Specify: White Specify: 'natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Motion Picture Engineer Entertainment other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of ည Floyd Leo Weber Frances Roth 20906 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Noreen Weber/Wife 3200 N. Leisure World Blvd. #220, Silver Spring, MD Baltimore, 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State Date Feb. 29, cemetery, crematory or other place) 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Francis Address Collyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Probable Ph. sician/ disease or condition Medical resulting in death) Due to (or as a cons **Examiner** Sequentially list condition Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached f Yes 2 No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? Yes 2 X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XNatural injury 5 Pending work? after death.

Director: Af 2 🗌 No the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier **Tpletely** (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Bichhum 29d, Date signed (Month, Day, Year) 70 D 54996 tebruary 2012

Registrar

State

31. Date filed (Month, Day

Prince

Vrive

20832

Philip

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-02014 Sean Moreland Wells

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	201	2	nglin
State of Maryland / Department of Health and Mental Hygiene	C V 1	Broke	0040

		1-For State Certificate of Death Reg. No.													
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Medical Exami		Sean Moreland	Wells								Month March 10,	Day 2012	Year		1005 hrs
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birth	day)	Months		Hours	T		,	16		Washington
Director		212-13-2642	1XM 2 F	34		Yrs.	IVIOITUIS	Days	Hours	141111.	February	12,1	.978	Cour	
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i, or		3 Widowed 4 Div	vorced If Yes, Give Ye			1	Yes 2	X No	specify:			Sp	ecify:	Wh:	ite
rs af ural	2	15. Decedent's Education (Spe	or Dates: ecify only highest gra	de completed)	16a. D	ecedent	s Usual (	Occupatio	n (Give ki	ind of wo	rk done	16b. Kind	d of Busin	ess/In	dustry
hou kr	8	Elementary/Secondary (0-12)		1-4 or 5+)	d	uring mo	st of work	king life, D	DO NOT	ise retired	d)	D			F. Dofones
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21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	Stewart M. We			_	-			Edith					-	2 - ACC - CALL
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MD dd 2 shoulth and in 27 is		Edith K. Wells	s / Mothe								an Fra				
Healt	- 1	20a. Method of Disposition						ne of ceme	stery,		Date	20c. Loc	cation - Ci	ity or T	own, State
t of J		1 Burial 2 X Cremation	n 3 Removal	from State		ny or othe		mator	.,	3/12	2/2012	Ale	xandı	ria	, Virginia
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	21. Signature of Funeral Service	e Licensee					Address o	-			+739	Balt	imo	ore Avenue
	- 1	Co yange	- RAY ROS	NS								-			, MD 20781
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876 iffica ng ph		23b. Was decedent pregnant in t		birth		Feta	al death	3	Ectopic	pregnand	су		onth	Da	ay Year
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Division of Vital Records, P.O. Box 68760, To the Bostial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medicai Ex	aminer:On the basis	s of examination	and/or in	rvestigati	on, in my	opinion,	death occ	curred at I	the time, date a	and place	, and due	to the	cause(s)
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·m	~	200. Organization and title of certifi	1	11	,		1	O.C.N					11, 20		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Williams Gloria 9:39 aM Η. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 093 Rockville Montgomery <u>Shady Grove Hospital</u> Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 11/17/1940 358-34-6810 **Director** 1 🗆 M 2**X** F IL. 71 death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f NY Erie Cheektowaga 1 X Yes 2 🗌 No 10e. Street and Number 10g. Citizen of What Country? ò Of. Zip Code Funeral ntal Hygiene. ed other than "natural", or items 23a event, the Medical Examiner must br β420 Genesee Street #B4 14225 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th C.N.A. Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Henry Douglas Mabel Curthird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 922 Beacon Square Ct. #223 Gaithersburg, MD Department of Health ar Important; If item 27 is any injury or other trauonce. Valerie R. Williams/Daug. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ridgelawn Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/10/12 Cheektowaga, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  ${f Thomas}\ {f T}$  . Edwards Funeral Home 995 St. Buffalo, Genesee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicass/ Myocardial disease or condition resulting in death) inuse ) Medical Due to (or as a consequence of) Examiner Imorory minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on Exami ul or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 use as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed? 1 Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending work?
1 \( \sum \) Yes 2 \( \sum \) No injury Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D 0065385 27,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pockville Rosin mi 9901 medical Alex 20850 31. Date filed (Mont) Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RALPH ELI WHITE FEBRUARY 2012 1421 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTERTOWN CHESTER RIVER HOSPITAL CENTER KENT Funeral Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F **81**^{Yrs.} 06/26/1930 Director MARYLAND 213-24-4636 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f 1 XYes 2 No MD **KENT** WORTON 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 10500 WORTON ROAD UNITED STATES 21678 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces 0 2 1 Never Married 2 Married 1 X Yes 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates 1951-53 WHITE th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 ELECTRCIAN AND PLUMMER MAINTENANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM R. WHITE SARAH ELIZABETH ELLIOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 VICKIE BLIZZARD / DAUGHTER 26870 BIG WOODS ROAD WORTON, MARYLAND 21678 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important; If ite any injury or ot once. 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 03/01/2012 STEVENSVILLE, MARYLAND Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND HOME 21620 uzh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between 5 udden Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): physician s the burial Physician/Medical certificate be Box 68760 attending IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? detached for Month Day Yes 2 No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed been 24a. Was an 24b. Were autopsy findings available Was a autopsy performed has prior to completion of cause of death?

1 Yes 2 No Yes 2 Division of Vital ours after death.

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Lucy Elizabeth Wood March 1:25 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 49806 Fresh Pond Neck Road Ridge St. Mary's 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Country) **Director** 220-16-7963 1 🗆 M 2 😿 F 86 07/05/1925 Maryland Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland St. Mary's 1 Yes 2 X No Ridge 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 49806 Fresh Pond Neck Road 20680 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 and Mental Hygie Is marked other Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Norris permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Innocent SAdie Ellen Ridge11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49804 Fresh Pond NEck Rd., Ridge, MD 20680 Linda L. Cullison/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Michael's 03/07/2012 Ridge, MD Sig ature of Funeral Service 2. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician Onset and Death disease or condition ) Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No 4 hours after death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

(10) RML

Avani D. Shah, M.D. 22650 Cedar Lane Court, Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pégistrar's Signature

31. Date filed (Month, Day, Year

MAR 05

47066

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		artment of F tificate of D		vientai Hy	gierie Reg. No. 2	012	08408		
П	Physicia	n/	1. Decedent's Name (First, Middle, Last,					2. Date of De	eath	Year	3. Time of Death		
X.,	Medic	al		lingfield		1		Februa			11:55 p. m.		
	Examin	er	4a. Facility Name (if not institution, give s	,	0.35		Location of Death			y of Death Mary 's			
2	Funeral		Chesapeake Shores 5. Social Security Number 6. Sex				If Under 24 Hrs.	8. Date of Bi	rth	9. Birthp	place (State or Foreign		
	Director			M 2 □ F 68	Yrs.	Months Days	Hours Min.	(Month, Da		Oklah	**		
	nd how at	'n	Usual Residence of Decedent  10a. State  10b. County		ty, Town or Lo	cation		04/26/	1943		Od. Inside City Limits		
	faryla Ba-f s tified	Director	Maryland St. Mary'	s Lexi	ington	Park					1 🗌 Yes 2 🛣 No		
	the h	Toe. Street and Number 10f. Zip Code 10g. Citizen											
	h with rs 23a rust b	Funeral	46221 Sylvan Court	:		20653			United	State	es		
9	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	11. Marital Status 1 ☐ Never Married 2 🐰 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No		Was Decedent of His f Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e			
003	urs aff .ural", al Exa	ted	3 🗆 Widowed 4 🗆 Divorced	If Voc Civo									
15-(	72 ho n "nat fedica	Completed	15. Decedent's Edi (Specify only highest grad		(Give i	dent's Usual Occupa kind of work done d O NOT use retired)		ing	16b. Kind of E	Business/Inc	dustry		
212	within /giene. <b>ner tha</b> <b>t, the N</b>		Elementary/Secondary (0-12)	College (1-4 or 5+) 2		ion Mecha	nic		U.S. Na	avy			
nd	d 2 should be filed with alth and Mental Hygien 27 is marked other th r traumatic event, the	o Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surnan	ne)			
Уa	uld be Ment narke	요	Unknown				Jessie L	ee Wing	field				
Mar	2 shouth and the and the strain traum		19a. Informant's Name/Relationship (Typ		1	g Address (Street a							
ē,	f Health item 27 other tra		Delia Wingfield/Wi	20b.	Place of Dispo	Sylvan Consistion (Name of	1	Date	20c. Location		)653 wn, State		
шo	Page nent or		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	icinovai nom ciale		natory or other place n Nat. Cer		3/2012		-	Virginia		
Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice re Danielle Ward	7	red 22	Name and Addres	s of Facility Br:	insfiel	d Funera	al Hon	ne, P.A.		
m	+		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the dea	th. Do not ente	er the mode of dying	, such as cardiac	or respiratory a	rest,	11, 110	Approximate Interval Between		
	Physician/ Immediate Cause (Final disease or condition Grown 4 6 Look 18570, Malliforme												
	Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
No.		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					-			
	outed nd ransit	Examiner	Cause (Disease or injury that initiated events										
	cate be executed physician and s the burial-transit	al E	resulting in death) Last	Due to (or as a conseq	uence of):								
760	cate b physi s the b	edical		l									
9	eath certific attending I for use as	M/m	Lob. Has account program	3c. If yes, outcome of pregna	ancy	] [			23d. Da	ate of delive	ry		
P.O. Box 68	or Attending Physician: The law requires that the death certificate be executed attending that death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			M	onth	Day Year		
P.0	es that the dea igned by the a be detached t	by Pr	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to the	e cause of death?		
ds,	requires been sig should b	ted						1 🗆	Yes 2 ☐ No	3 🗌 Prob	ably 4 nknown		
Ç	law rei nas be e 2 shr	Completed			***			24a. Was auto	psy	prior to con	sy findings available npletion of cause of		
Re	sician: The law certificate has l lirector, page 2 s							1 🗆 Yes	2 No	death? 1  Yes	2 🗆 No		
/ita	ysiciar is certif directo	m	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	LED/O. t#	Othe	r: X						
of/	g Physer this	te: To	27. Mann of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury	at Nursing Ho		dence_6 □ Oth now injury occur				
on	tending Jeath. Ior: Afte the fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(IVIOIIIII, Day, Year)	injury	M 1 🗆	Yes 2 No						
Division of Vital Records,	l or Att after d Directo d in by	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (3 City or Tov	Street and Numb vn, State)	er or Rural	Route Number,		
	Hospital 24 hours Funeral I	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examina	ian: To the best of my knower: On the basis of examinatio	rledge, death o	occurred at the time,	, date and place, a	nd due to the c	ause(s) and man	ner as state	d.		
	To the P within 2. To the F complet	Me		Practitioner: To the best of	my knowledge,	death occurred at th	e time, date and pla	ace, and due to	the cause(s) and	manner as st	tated.		
	¥ ≥ ¥ 8		1 Joel 1	n Julie	CM)	23	number 4198		29d. Date signe	A (IVIOITIII, D	ay, (Gai)		
	.0 -	ł	30. Name and address of person who co	*									
OX.	me		David M. Federle	M.D. 24035	Three	Notch Ro	ad, Holl	ywood,	MD 206	36			
	Stat Registra	e ir	31. Date filed (Mont MAR 0 6 20	32. egistrar's Signa	ture.	ale							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb 21, 2012 Joseph Woods 11:25 PM James 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Cumberland Allegany 7. Age (In yrs. last birthday) Social Security Number 92 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Oct 14, 1927 1 🕅 M 2 🗆 F 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cumberland Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 828 Windsor Road 21502 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Divorced WWII Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>purchasing agent/ inspector</u> Babcock & Wilcox 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Bernard Woods** Jane Knatz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Elizabeth Woods wife 828 Windsor Road MD 21502 Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Xremation 3 Removal from State Scarpelli Funeral Home, P.A. 2/23/2012 4 ☐ Donation 5 ☐ Other Specify) Cresaptown MD of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a, Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Due to (or as a consequence of):

Ph_sician/ Medical Examiner

Physician/

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Examiner

**Funeral** 

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Department of Important: If it any injury or o

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Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036

> and burialphysician the nse fo signed by i been certificate has page 2 funeral director, this After 1

Completed

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Certificate:

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within 24 hou

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760

Examine that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending wor Investigation Accident 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centry Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of dep

29c License number

00033280

Feb 22, 2012

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grupta 31. Date filed (Month, Day,

FEB

24

Kent Ave. Ste. 101 Cumberland, MD 21502 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mar 2, 2012 5:45 AM ^M Wilson Ann Patricia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany New Hope Assisted Living Cumberland 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number **Funeral** Country Months Hours Min. Aud 25, . 1<u>932</u> 79 Director 217-30-<u>1541</u> Usual Residence of Deceden show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State filed within 72 hours after death with the Maryland **Funeral Director** or 28a-f sl Cumberland MD Allegany 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 5 must be r 21502 USA 11609 Bierman Drive "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 Divorced white Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical.1 once. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wilson Construction Co. owner/ operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Frances Hood James A. Holloran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 Swallow Falls Road Oakland MD 21550 19a. Informant's Name/Relationship (Type, Print) Elizabeth Wilson daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1X Burial 2 Cremation 3 Removal from State ss Peter & Paul Cemetery 3/5/2012 MD Cumberland 4 Donation 5 Other (Specify) gnatur of Funeral Service Licensee 22. Name and Address of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final Ph_sician/ 112 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to lor as a consequence of if any leading to immediate cause. Enter Underlying sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Yes cate has been siç ; page 2 should b Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page ☐ Yes 2 ☐ No Yes 2 25. Was case referred to managed 26. Place of Death (Check only one) Be NEW HOLL examiner? Hospital: Other (Specify) ASSISTED LIVIN 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manne eath 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \[ \text{Yes} 2 \[ \text{No} \] Natural injury 5 Pending ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 40 30. Name and address of person who comp MI

State

Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ VERNON WEBSTER GERALD 6:45 AM 24-2012 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomica Constal Salisbury Hospice at the take Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 577-48-8471 **Director** 1 🗶 M 2 🗆 F 77 DC JULY 8, 1934 Usual Residence of Decedent show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director 28a-f SELBYVILLE 1 Yes 2 X No SUSSEX DELAWARE 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? must be Funeral 23a USA 19975 37625 RIVER RUN items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. Was Deceue... Armed Forces? Yes 2 X No 14 Race - American Indian 11. Marital Status the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ŏ 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Completed Webster 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) FOREMAN GAS 12 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of မ WEBSTER KENNETH V. EAKLE LEONTINE traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 37625 RIVER RUN, SELBYVILLE, DE. 19975 CATHERINE M. WEBSTER/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) GATE OF HEAVEN CEM. 4 ☐ Donation 5 ☐ Other (Specify) 3/2/12 DAGSBORO, DELAWARE 21. Signatur - Fu eral Service Lice 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 14 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ MALIGNANT LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last -burialattending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the all be detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Yes this certificate 1 Yes I or Attending Physician: after death. 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Certificate: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at After i 1 Matural 5 Pending 1 Tes 2 No Accident Investigation Director: 3 Suicide 4 Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Hospital within 24 hours a To the Funeral L completely

Hospital

State Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifie

Year

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bre

Registrar's Signatur

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 6:35 PM Elaine Ann Weller MACH 02,20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hagerstown Washington Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours **Director** 200-32-9549 1 □ M 2 🗓 F 71 Yrs. 01/06/1941 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director 1 X Yes 2 No Hancock Washington 10e Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or must be r Funeral IISA 21750 108 West High Street "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any riginry or other traumatic event, the Medical Examinone. Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Washington County life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Board of Education Instructional Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Anna Louise Kososki Michael Walter Golden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Cleveland Dr. Hancock, MD 21750 Laura L.Robair-Bivens/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 03/06/2012 Hancock, MD St. Thomas 'Episcopal Funeral Service Licer 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertension Immediate Cause (Final Pulmenery SIVERC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Corpulmon Sequentially list conditions, it any, reaching to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last 520515 and the burial-trail Due to (or as a consequence of): attending physician Physician/Medical DISCESE the Hospital or Attending Physician: The law requires that the death certificate be monoro Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Dav 5 Other (specify) Pregnant at time of death ed by the a detached f been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy this certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 2 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural iniury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: A
completely filled in by the? 6 🗌 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥

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FARID

31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MURSHED

5 2012

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			for State	State o	of Marylan		artment of H		and M	lental Hy	giene	310	001.11.		
			Registrar  1. Decedent's Name (First, Middle	- ( aat)		Cer	tificate of D	eath_			Reg. No.	114	06414		
Н	Physicia		Mary V	. ,	dron					2. Date of Dea	ath ary 23,	Year 2012	3. Time of Death		
parties.	Medic Examin		4a. Facility Name (if not institution				4b. City, Town, or	Location of	f Death	reprus	4c. County of Death				
	,		Montgomery Ge	neral Hos	pital		01ney	20041101101	Doam			Montgomery			
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ <b>X</b> F	7. Age (In yrs. I	• •	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign		
	Director		032-10-8568 Usual Residence of Decedent	I LI WI Z LINE	94	Yrs.	Wionins Days	Tiours	IVIII I.	Jan 4,	1918	918 Rhode Is:			
	and show at	o.	10a. State 10b. County		10c. Cit	y, Town or Loc	cation						10d, Inside City Limits		
	Maryla 18a-f tiffied	rect	MD Carr	011	Finl	ksburg						1 ☐ Yes 2 🔀 No			
	a or 2 be no	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Cou	ntry?		
	h with	ner	874 Ridge Roa				21048		USA	A					
	r deat r iten iner		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	Armed Fo			Vas Decedent of His Yes, specify Cubar	spanic Orig n, Mexican,	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		ace - Ameri ack, White,			
920	s after "al", o Exam	d by	3 ⚠ Widowed 4 ☐ Divorced	1,00	е	1	☐ Yes 2 🖾 No	Specify:		fy: Whi					
2-0	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decede	ent's Usual Occupa	ation		1	16b. Kind of	Business Ir	dustry					
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Ĕ	Page ment o ant: If ury or		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S				tan Crema		2-2	4-12	Alexa	ndria	, VA		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signate June 15, rvice L	icensee 3 und	12 12	22. 10	Name and Address	s of Facility	The Ber	Burbag lin, MI	ge Fune 21811	ral H	ome		
			23a. Part 1. Enter the disease, or	complications that comply one cause on an	aused the death	n. Do not ente	r the mode of dying	ı, such as c	ardiac or	respiratory arre	est,		Approximate		
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Pneumonia												Interval Between Onset and Death			
June	Medical Examiner		resulting in death)	a. Due to (	or as a consequ	ience of);							3 Days		
		Į.	Sequentially list conditions,	b											
	sit sit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	Due to (	or as a consequ	ience of):									
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ο̈́ ×	eath certific attending p	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregnar Birth 2 🗌 Feta	ncy I death 3	Ectopic pregnancy	7				ate of deliv	. ,		
P.O. Box 68760	e deat the at hed fo	Physician/M	1 Yes 2 No 9 Unknown	4 Pregi 9 Unkn	nant at time of d own	leath 5	Other (specify)				N	lonth	Day Year		
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s S	n sign	ed by	Coronary Arte	ery Diseas	se					1 □ Y	es 2x No	3 🗌 Pro	bably 4 🗆 Unknown		
Ö	w req	plet	Hypertension							24a. Was a		. Were auto	psy findings available		
Rec	The la ate ha bage 2	Completed								autops perfor	med?	death?	mpletion of cause of		
<u> </u>	ctor, I	Be	25. Was case referred to medical examiner?				26. Pla	ce of Death	(Check		2 (24) 140	1 103	2 4110		
$\leq$	Physic this o	은	1 Yes 2 No		Inpatient 2			4 L Nur	sing Hon	ne 5 🗆 Reside	ence 6 🗌 Ot	her (Specify	)		
Division of Vital Records,	ding F h. After funera	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pendin	9	h, Day, Year)	28b. Time of injury	28c. Injury work?	at ∕es 2⊡ N	í	8d. Describe ho	w injury occu	rred			
Sio	Atten r deat ctor:	rtific	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 280 Place	of Injury - At hor	me, farm, stre	M 1 1 Y	res Z 🗆 I	-	8f. Location (St	treet and Num	her or Rura	Route Number,		
A b s s s s s s s s s s s s s s s s s s											modic Mambol,				
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	<b>l</b> edical	(Check 2 L Medical E	Physician: To the be xaminer: On the basi Nurse Practioner: 1	is of examination	and/or investig	gation, in my opinior	, death occ	urred at t	he time, date an	nd place, and d	ue to the ca	use(s) and manner stated.		
	To th withir To th comp	Σ	29b. Signature and title of certifier		2001 OF THY		29c. License		piace		29d. Date sign				
			1 Gran	1	50		D18726	5			02/23/	2012			
-			30. Name and address of person		,	, , ,,	int)				_				
J)	トリン Stat	0	Arthur Schoenge 31. Date filed (Month, Day, Year)	old, MD 1	8101 Pr		hilip Dr.	. 01ne	ey, l	MD 2083	2				
	Registra	ir	31. Date filed (Month, Day, Year) MAR 0	1 2012	numa.		arke								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Alton Eugene Windsor 24 2012 9:50 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dorchester Mallard Bay Care Center Cambridge . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) 212-40-9428 79 Director 1 K M 2 🗆 F Yrs. June 22, 1932 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Madison 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1057 Taylors Island Road 21648 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

Yes 2 X No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2x No Specify: Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ waterman seafood should be filed with and Mental Hygier 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Austin Windsor Eulalia Murphy traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Larry Vaughn Windsor 2066 Bishops Head Road, Toddville, MD brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Old Trinity Churchyard 3/1/12 Church Creek, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Si tura Funeral Service 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ STAGE DEMENTIA. END disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Be ၉ Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for more than the funeral director. Division of Vital Records, P.O. Box 68760

		24a. Was an autopsy performed? 1 ☐ Yes 2 № No 1 ☐ Yes 2 № No 1 ☐ Yes 2 № No										
25. Was case referred to medical examiner?	26. Place of Death (Check only one)											
1 Yes 2 No	ospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)											
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? n M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred										
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
00- 0-455 1 <b>(1)</b> 0-456 Db	rejeium. Te the burst of your live surface of each programmed at the time, what and place and	due to the series(s) and manager as atotad										

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

29c. License number D69234

2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continued Practition on To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 28, 2012

MO30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERRABOLU 503 BYRN

CAMBRIDGE MD 21613.

Registrar

Medical

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	•	for State Registrar		Otato or in	ai y iai i			te of L				g. No. 2	112	0.8	416		
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/Medic Examin		4a. Facility Name (/	f not institution, given	re street and number)			4b. City	, Town, or	Location of Deat	th		4c. Cour	nty of Dea				
		Frank		race Hos	spit	al	RO	sedo	Ne			Ba		more			
Funeral		5. Social Security N 233–38–6		Sex 7.Ag ISXM2□F		a <i>st birthd</i> ay) Yrs.	Month:	or 1 Year Days	If Under 24 Hrs Hours Min.	. (N	ate of Birth fonth, Day,	Year)	C	thplace (State ountry)			
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MO #		10a. State	10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits		
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or items 23a or 28a-f show	Director	10e. Street and Nur	nber				10f. Z	ip Code			10	g. Citizen o		ountry?			
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items	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	ces? If Yes, specify Cuban, Mexican, Puert						es or No- , etc.)		ace - Ame lack, Whit	erican Indian, te, etc.			
,or	by	1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married	1 Mayes 2 □ I If Yes, Give Year or Dates:	NO		1 □Yes	2 🔯 No	Specify:			Spec	oify: Wh	nite			
atura			15. Decedent's E		16a. Dece	dent's Us	ual Occupa	ation		1	6b. Kind of	Business	/Industry				
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ntal H hd ott	Be	17. Father's Name (First, Middle, Last)  James O. Browning  18. Mother's Name (First, Middle, Maiden Sumame)  Mary Jane Harrison															
d Me marke	ဥ	19a. Informant's Na				10h Mailie	na Addroi	e /Stroot o	and Number or R				n Stata	Zin Code)			
than than 7 is r		Kevin Ru		Friend			_		ood Road								
f Hea		20a. Method of Disp	position		20b. PI	lace of Dispo				Date Ch 1				Town, State			
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ath. rr: Aft	Certification:	1 ☑ Natural 2 ☐ Accident	5 Pending investigatio	n	ly, rear)	Hijuly	M		res 2 □No								
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within 24 hours after death.  To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one)		hysician: To the best miner: On the basis o and manner st	of examinat										∋(s)		
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		30. Name and addr	ess of person who	completed cause of c	leath (Item	23a) (Type.	Print)	1) 1	71)			l					
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Sta		31. Date filed (Mont	th, Day, Year	9000 F (0	ar's Signat	ture	11				-,-						
Registr	ar	MAR	1 9 2012	Course	A.	Mark											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Sterling C. Bower  $P^{M}$ 2012 MArch 16, 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 37 Yawmeter Drive Middle River Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral 1**X M 2□ F 214-44-6081 Director 67 April 13, 1944 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 Yawmeter Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Manufacturer Lever Brothers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sterling C. Bower Helen Stafford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Bower wife 37 Yawmeter Drive, Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot March 19 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 2012 21. Signature of Funeral Service Lice Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 XMan MO1176 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm e Cause (Final disease or condition resulting in death) **Physician** uamou (gr Cun ans manch /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death Month Day Year P.0. 5 Other (specify) the detached 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy The page perform certificate Division of Vital 2 No 1 ☐Yes 2 No 1 ☐ Yes Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or ..... within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number D - 38 7-54 29b. Signature and fitle of certifier 29d. Date signed (Month, Day, Year) M.D. 03-16-2012

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

709.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NASERM

State

FASTERN BLVD. MD-21221.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08418 For State Registral Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 0^{Month} Day 20^Y1°2 Roxie Ann Burris 11 6:50p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death N/A Gilchrist Hospice Baltimore 5. Social Security Number 213-76-4670 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 1 M 2 X 54 08/23/1957 Maryland 28a-f shov 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore Co. 1 Yes 2X No MD Dundalk J. 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1100 Steelton Ave. 21224 U.S.A. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces ò 1 Never Married 2 X Married 1 ☐ Yes 2 ☐xNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Disable N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Burris Rita Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathan Madison(son) 2303 Whittier Ave., Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State On-site Crematory 03/13/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, 21. Signature of Funeral Service Licensee Joseph Adres of Brown Jr. Funeral Home PA 2140 N. FUlton Ave., Baltimore, 239 Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or judant failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 1 Yes 2 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Melli trus Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSSECE ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending work 1 Yes 2 🗌 No 24 hours after death. Funeral Director: A Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 within 2 To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

D0071187

st. * 4105, Baltimere

3-12-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year John Wesley Butler 2012 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore N/A OVEFLEA HEALTH AND REMAB. CENTER 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/08/1944 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min. 1 **□**₩ 2 □ F 212-44-5141 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No Baltimore N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4410 Bowley's Lane 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 □Yes 2**x** No Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th Grade College (1-4or 5+) Roofer Seal Coat Roofing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Burns Joseph Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4410 Bowleys La., Baltimore, MD 21206 Rosalie Butler(wife) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State On-site Crematory 03/16/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Forephaders of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23 Part 1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCEL Due to (or as a consequence of) Sequentially list conditions, Due to for as a nonsequance of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 🛂 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical Examiner Examiner death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Completed by Funeral Director

2

death with the Maryland

Maryland 2121

Baltimore,

Box 68760.

o

Records,

Division of Vital

Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene.

is marked other

permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau

ician and burial-tran physician s the burial attending properties for use as signed by the detact certificate After thi funeral Hospital or Attending

Physician/Medical Completed Certification: To

n 24 hours after death.

The Funeral Director: After the further t

	as case aminer?	referred	to	medica
4.6	<b>-</b> 24			

27. Manner of Death 1 Natural

29b. Signature and title of certifier

3 Suicide 4 Homicide

29a. Certifier (Check only one)

6 ☐ Could not be

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

So Hurch ND

D0061789 MARCH, 11, 2012.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOPPAINE OFOR AW VAHIMO- 5430 CAMPBELL BLVD, STE 214. BALTIMORE MD 21236 31. Date filed (Month, Day, Year)

State Registrar

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:50 AM DELANO JOHN MARKEN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SINA HOSPITAL BATTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) John Dalano **Funeral Director** 1 M 2 - F 08-06-1940 Usual Residence of Decedent 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the <u>Medical Examiner must be</u> notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director BATIMORE MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral CEDARDALE ROAD 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Butter Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 ₩ Widowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4 or 5+) NURSING TECH HEALTHCARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fatient Known as ည MARGIE SUMNER BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4049 CEDARDAL RD. BALTO, MD. 21215 NOBLE /DAUGHTER DELNORA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

RBUTUS CEMETERY 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3/10/12 BAUTIMORE, MD RBUTUS 22. Name and Address of Facility VAUGHN GREENE FUNDRAL SWS MO155 ROAD. BALTO 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on sach line. Approximate nterval Between Immediate Cause (Final disease or condition Onset and Death Physi_ian Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Unknown Part II. Other significant conditions contributing to death/but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performe 2 🗌 No 25. Was case referred to 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes ည To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir ≥ N ER/Outpatient 3 □ DOA 1 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 29c. License number completed cause of death (Item 23a) (Type 30. Name and address of person who 20/2

State Registrar Date filed (Month, Day, Year)
MAR 1 9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ crane Month Year Aaron 1:404 M March 2017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE . Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 213-09-4979 Director 1 X M 2 □ F 93 Yrs. 04/01/1918 MD Usual Residence of Decedent 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f MD N/A 1 X Yes 2 No BALTIMORE 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2901 FALLSTAFF ROAD, #406 21209 USA and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or items: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates WHITE marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 TECHNICAL WRITER & EDITOR US NAVY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ LOUIS CRANE ROSE DACHSLAGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the once. LILLIAN CRANE / WIFE 2901 FALLSTAFF ROAD, #406, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 03/16/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Scott 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscherotic Cardiovascular Disease Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-trar resulting in death) Last Due to (or as a consequence of). Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year 1 Yes 2 L 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performed? Yes 2 No death? 1 Yes Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After it 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mayapathem) DOUS 7465 3/15/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NS Ruja Pall JUMP 283 S Smith NV S 2 2835 Smilh N 5203 Baltimore MD 21709

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death lent's Name (First, Middle, Last) 1. Dece Date of Death Physician/ Reu 211 GL AS Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALTIMORE Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Country) **Director** show 10d. Inside City Limits 10a. State 10c. City. Town or Location by Funeral Director notified 1 ¥Yes 2 □ No 28a-f 10e Street and Number ò 10g. Citizen of What Country? must be r 704 4Th ST. 1.5.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner rmed Forces?
Yes 2 \( \sqrt{No} \) Black, White, etc. ò 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☑ No "natural", 3 Widowed 4 Divorced Completed 16 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the r traumatic event, the COUNTY GOVERNMENT Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ JOSEA. LOIS EDNA HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 446 PARK CREEK RD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DENTON, MD. INTAIN RD. PASADEAM 23a. Part 1. Enter the disease an emplications shock, or heart failure. List only one cause plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death -each line Immediate Cause (Final Physician/ disease or condition resulting in death) neumor Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has boon about the funeral Director. P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No Yes 2 Co 1 🗌 Yes director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Oth filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15^{Day} Physician/ 2012^{Year} Month March 9:45 P Marjorie Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NA Future Care Nursing Home Sandtown Baltimore 8. Date of Birth
(Month, Day, Year)
06-17-17 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 - M 2XX Hours 219-32-7785 94 Country) Director Usual Residence of Decedent or 28a-f show 10a. State 10b County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** NA MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 1000 N. Gilmor Street 21217 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. African Completed by 1 X Never Married 2 Married Yes Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th Grade College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. unk. ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212231700 Edmondson Avenue Apt. #406 Baltimore, MD. Theresa Ellis-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify 03-17-12 Catonsville, MD Metro 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** equentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy death? performe 2 X No Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 🗌 Yes 21 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes I Director: / Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an title of certifie 29d. Date signed ( 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1025 March! MEYER FISHER 2012 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death COURTLAND GARDENS BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Numbe 6. Sex 1 ፟ M 2 ☐ F . Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Director 04/03/1923 214-14-9053 88 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2205 FALLS GABLE LANE, UNIT L 21209 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 Divorced Specify: Year or Dates WHITE er than "natur , the Medica∐ 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the BAKER FOOD 1 and 2 should be filed w. f Health and Mental Hygivitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ JOSEPH FISHER BESSIE CAPLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN FISHER/SON 12528 WAR ADMIRAL WAY, N. POTOMAC, MD permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS 03/15/2012 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Further the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between On let and Death Immediate Cause (Final Physician/ 11 Con 1 disease or condition nen Medical resulting in death) Due to (or as a consequence or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Month Day Year 2 🗌 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performe Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 Ho Be 26. Place of Death (Check only one) Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Ursing Home 5 Residence 6 Other (Specify, 27. Manner of Deat 1 D Natural 2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendis within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 434

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

3clh Nore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day MARCH 12, 2012 Year ARLENE FREEDMAN 9:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign Hours Min. 053-30-1156 Country) **Director** 1 🗆 M 2 🗓 F 75 07/15/1936 Usual Residence of Decedent RI28a-f show 10a. State 10b. County with the Maryland must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 Yes 2 X No BALTIMORE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 130 SLADE AVENUE, #212 21208 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KRYSHKA SADIE SEILER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S of Health a item 27 is STUART FREEDMAN/SON 8424 HARRIS AVENUE, PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō ± 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once. MOSES MONTEFICRE 4 ☐ Donation 5 ☐ Other (Specify) 03/15/2012 BALTIMORE, MD Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause ____ach line. Interval Between Onset and Death Immediate Cause (Final Physician/ av U cal Cancer montas Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Liretan 35 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No 2 🗌 No 1 🗌 Yes filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 DOther (Specify) NOSPIC 27. Manner of Death 28b. Time of e Hospital or Attending Po n 24 hours after death. e Funeral Director: After t Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work' Accident Investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifie MARCH 12 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST, TONSON, MO CHARLES MO

Registrar

DHMH 17 Rev 06-2011

ed (Month, Day, Year)
NAR 1 9 2012

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State of Maryland / Department of Health and Mental Hygiene 2 Ortificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 Ortificate of Death

Reg, No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **B**ay MaYch 20 Tra 6:30  $A_M$ Lloyd Herbert Graf Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Mt. Airy Frederick Kline Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept 14, 7. Age (In vrs. last birthday) **Funeral** -14-4026 9. Birthplace (State or Foreign Months Days 1 X M 2 D F Hours Wisconsin **Director** Yrs 92 '1919 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick 1 Tes 2 No 10f. Zip Code 21702 10e. Street and Number 10g. Citizen of What Country? 618 Wilson Place Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ò 1 Never Married 2 K Married hours after Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 biochemistry biochemist Be 17. Father's Name (First, Middle, Last) Should be file and Mental H 18. Mother's Name (First, Middle, Maiden Sumame) Rosa Sell Herbert Graf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Wilson Place; Frederick, MD 21702 Catherine Graf - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Ronald S. 21. Sign 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) orona Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): and I-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) inding physician a use as the burial-1 Physician/Medical Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Pregnant at time of death signed by the a g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifit completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2**X** No Other: 1 Yes |은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of p

31. Date filed (Month, Day,

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son who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear SR 03:51 March 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mulaland timore Medica Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 216-62-1441 1 X M 2 🗆 F **Director** 58 MARY/AND permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MMY/AND 10e. Street and Number 10g. Citizen of What Country? Funeral 3707 6th Street 21225 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates White Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

CARPEN LCR (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Golden Touch H. I. 64 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Gold ပ Eldon IERCE LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 23a. Part 1. Enter the di shock, or heart fall Immediate Cause (Final se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician/ uno disease or condition Medical resulting in death) Due to (or as a consequence) f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusion. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year been signed by the s should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed completely filled in by the funeral director, page 2 2 🗌 No 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1. Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d, Date signed (Month, Day, Year) 2012

Registrar
DHMH 17 Rev 06-2011

State

Andrew

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

terman

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	ate of Maryland /		rtment of H			giene Reg. No. 20	2 08428	
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)  Bornice Hawkins  4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of C	2. Date of Dea Month March	Day Ye		
	Funeral Director		Bon Secont Hospita  5. Social Security Number  578-92-2055  6. Sex  1□ M	7. Age (In yrs. last	birthday) Yrs.	Rank mo If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birth Min. March		Buth none Birthplece (State or Foreign Country)	
the Monday	or 28e-f show	Director	Usual Residence of Decedent  10a. State  10b. County  MD  10e. Street and Number  1217 W. Fayette St.		own or Loc				10g. Citizen of Wha USA	10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	penint. Tays a lance as shown between the main of nous area bean min the maryana Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status unk 12. WAA AA 1 Never Married 2 Married 1	/as Decedent Ever in U.S. mned Forces? unk  yes 2 No Yes, Give ear or Dates:	lf 1	Yes, specify Cuba	Specify:	? (Specify Yes or No- querto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black		
7 6 1 2 1 2 L	Hygiene. ther than "natu nt, the Medical	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) unk  17. Father's Name (First, Middle, Last) un	ollege (1-4or 5+) unk	(Give I	ent's Usual Occupa kind of work done o OO NOT use retired	furing most of	f working  Name (First, Middle,		ess/industry unk	
Mai yiaiik	th and Mental by is a marked of traumatic even	To Be	19a. Informant's Name/Relationship (Type, F Bon Secour Hospita)	Print) 1		•	and Number o	or Rural Route Number St; Balti	er, City or Town, Sta	ite, Zip Code)	
iniliore, i	in rayes in an interest of Healington 2 injury or other in		20a. Method of Disposition  1  Burial 2  Cremation 3  Remove 4  Donation 5  Other (Specify) I II  21. Signature 1 Famoral Service (Specify)	20c. Location - Cit	ation - City or Town, State						
Da	Depa Impo any ir		23a. Part Enter the disease, or complication shock, or heart failure. List only one ca	use on each line.	o not ente	655 W. B	altimo	re St; Bal	timore, N		
E	hysician and physician and physician and physician and physician and the pritial transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause That In Information (Cause (Disease or injury that initiated events resulting in death) Last  d	Du+ to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to	ce of):	eding					
DO TO TO TO	y the attending I	Physician/Med	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal dea Pregnant at time of death Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year	
ecolos, r	nas been signed t e 2 should be det	Completed by P	Part II. Other significant conditions contribu		_		en in Part I.	1 🗆 Yas	res 2 □ No 3 ( an 24b. Wei	re autopsy findings available	
DIVISION OF VIIAL RECOIDS, P.O. BOX 00/00,	To the propried of which the properties. The terr requires that the death centure be executed. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospii  27. Manney of Death 1 Natural 5 Pending 2 Accident investigation	1   Inpatient 2   EH/	Outpatient b. Time of Injury	t 3 DOA Other	er: 4 □ Nursi	1 ☐ Yes Death (Check only ong Home 5 ☐ Resident 28d. Describe h	ne)	Yes 2 No	
SIVIO	nours after des neral Directo	al Certification;	4 Homicide  29a. Certifier 1 Certifying Physicial	Be. Place of Injury - At home building, etc. (Specify)	dge, death	occurred at the tim	ne, date and p	City or Tow	vn, State) cause(s) and mann	or Rural Route Number, er as stated.	
C. C. C. C. C. C. C. C. C. C. C. C. C. C	within 24 i To the Fu	Medical	(Check only 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Examiner: 2 Medical Exam	On the basis of examination and manner stated.		29c. License	number		29d. Date signed (P	Month, Day, Year)	
*	Sta Registr			M.D. 2000	W.B	althore wes	St, B.	altimore	MD		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Groth UVS 1:38 Medical 2012 March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death lizabeth al timove **Funeral** If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days **Director** 216-14-8108 Months Min 89 Maryland Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Logan View Drive 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates. Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 vears Cashier Western Electric Cafeteria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael J. Gummer Mary Milanicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Nerf Daughter 7945 Oakwood Road, Glen Burnie, Md. 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Marchate 16 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 2012 Signate of Funeral Service Lice ²² Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition ment Medical resulting in death) Due to (or as a consquence of): Examiner Sequentially list conditions, Examine dramy, trading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year Unknown Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 🗌 Yes 2 X No 3 🗌 Probably 4 🗌 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy certificate performed Yes 2 X 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No ပ 1 🗌 Yes Other: after death. Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury Investigation 6 Could not be M 1 ☐ Yes 2 ☐ No 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral E Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f 29b. Signature and title of certifier

State Registrar

31. Date filed Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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an

Registrar's Signature

DHMH 17 Rev 7/2009

Avenue

0553

			1 - For State Registrar		f Marylan	d / Depa		of He	ealth a		ental Hy		2 U	12	08	430
	Physicia		1. Decedent's Name (First, Middle, Mary	John,	SON						2. Date of De Month	ath Da	7	Yeer 2012	3. Time o	Death M
•	/Medic Examin		4a. Facility Name (If not institution, s	give street and nu	mber)		4b City T	own, or		Death		40	County of	timo	re.	
	Funeral Director			Sex 1□M 至F	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 12/24	th / 40		9. Birthi Cou M	place (State ntry) D	or Foreign
	aryland ahow	٦.	Usual Residence of Decedent           10a. State         10b. County           MD         N/A			y, Town or Lo									10d. Inside C	ity Limits
	with the M s or 28a-f be notifie	Directo	10e. Street and Number 2635 E. Madiso	on St.			10f. Zip 0	Code 212(	)5			_	izen of W	/hat Cou	ntry?	
000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the stite and Mental Hygiene. If the the marked other than "natural", or Itema 23a or 28a-f ahow other traumatic event, the Musical Extending mass be notified at	by Funeral Director	11. Marital Status  1 □ Never Mamed 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Dec Armed Fo	2 ⊠No ve		Was Decede f Yes, specif		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - American Indian, Black, White, etc. African SpecifAmer,			
2.612.2	d within 72 ho giene. er then "neturi	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (	1-4or 5+)	16a. Decec (Give life. Hou	dent's Usual kind of work DO NOT use SEKE	Occupa done di retired)	tion uring most	of workir	ng		ind of Bu			
Jaila	uld be file Mental Hy srked oth stic event	To Be (	17. Father's Name (First, Middle, La Frank Gough	ist)					Cari	r's Name r1e	(First, Middle Gough	, Maider	Sumam	е)		
, ivial )	and 2 sho salth and I n 27 is me er traume		19a. Informant's Name/Relationship Carlene Johns	o (Type, Print) on/Daug		2635	E. 1	Mad:	ison		,Balt	. , M	D :	2120	)5	
Dailliora	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe		State Mt	Place of Dispo cemetery, cren Car	mel (	Cem	•		^{at} /7 1 2	Ва	lt.	, MD	own, State	
Dail	permit. Departu Import any inj		21. Signature of Funeral Service Co			5	126	Bel	air 1	Rd,E	P. C Balt.,	MD	e F. 212	.Svs	PA 5105	
š I	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a Acu	ite Re	traices	-	of dying		cardiac o	r respiratory a	rrest,		•	Approxima Interval Be Onset and	tween Death
	Examiner	Je.	Sequentially list conditions, if any leading to immediate	b. Phei	(or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the cons										3wee	ks
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OI US, T.	uires that t signed by id be detai	þ	Part II. Other significant condition Chronic Obstru	1	leath but not res	sulting in the u	nderlying ca	use give	n in Part I.			tobacco Yes 2		nbute to	the cause of	death? Unknown
וו שבכחו	: The law req cate has beer page 2 shou	Completed			/						24a. Was auto perfi 1 Yes		F	orior to co death?	opsy findings ompletion of 2 \( \subseteq \text{No} \)	available cause of
Altai	nysician nis certifii i director	To Be	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO/	A Othe			<i>(Check only</i> me 5 ☐ Res		6 □Oth	er <i>(Spec</i>	ify)	
	Attending Pt r death. ector: After th by the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin	tion t be 28e. Place	of Injury oth, Day Year) e of Injury - At h ling, etc. (Speci	28b. Time o Injury	М		at ? /es 2 🗆 l	No	28d. Describe 28f. Location City or To	Street a	nd Numb		al Route Nu	mber,
5	ospital or hours afte uneral Dis ly filled in	cal Cer	29a. Certifier 1 Certifying	Physicien: To the	e best of my kno	owledge, deat	h occurred a	at the tim	e, date an	d place, a	and due to the	cause(s	and ma	inner as	stated.	(e)
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier		ner stated.		290	License	number			29d D:	ate signe	d (Month	Day Year	
_			204 Name and address of parent w	bo completed cau	Co. of doath (lea	1 N	Print)	1360	526	7		Ma	~ (	6	2012	
クリ	/		30 Name and address of person w li labalabai 31. Date filed (Month, Day, Year)	200	0 W.	Ball	Simore	ر ا	tree	t, 1	Saltin	ure	M	D	2123	33
15	Sta Registr		MAR 19	2012	egistrar's Sign	B. A	aves									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Month Physician/ March Medical Kirchenbauer 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Home Airy **Funeral** Social Security Number Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth Months Hours Director 213-01-9594 96 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director or 28a-f Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral 631 Eliot Road 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married ò 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Esterka Frances Vasicek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane G. Kirchenbauer (Daughter) 1457 Fannie Dorsey Road Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important; If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 03/19/2012 Brooklyn Park, Maryland 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. M00 - 732<u>3204 Mountain Road Pasadena, Maryland 21122</u> 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CONGESTIVE HEART disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CHRONIC RENAL Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed ANEMIA 24a. Was an autopsy Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Other: မ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Suicide Investigation Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DO052861 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 PIKE, CLARKEVILLE

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

1 Yes 2 No

Virginia

12:38 PM

2012

Carrol1

U.S.A.

14. Bace - American Indian.

Own Home

23d. Date of delivery

death? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of

Month

White

Black, White, etc.

Specify:

DHMH 17 Rev 7/2009

State Registrar 12640

31. Date filed (Month, Day, Year)

CARKSVILLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ JESSE KING 08:28 A M MAR 16 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HARBOR BALTIMORE 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Days Hours Min. Country) Director 214-68-4500 04-06-57 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Maryland Director notified X□ Yes 2 □ No 28a-f Glen Burnie MD Anne Arundel ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral **USA** 21060 308 Blue Water Court Condo #304 items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 'natural", or þ 1 Never Married 2 X Married 1 Yes 2XXNo
If Yes, Give
Year or Dates. filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced American the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Planet Fitness Maintenance 12th Grade 3vrs. Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk. and Mental F 1 and 2 should be file of Health and Mental item 27 is marked o ပ Hughes V. Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 19a. Informant's Name/Relationship (Type, Print) 308 Blue Water Court Condo #304 Glen Burnie, MD. Donna Lee King-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 03 - 19 - 12Catonsville, MD Metro Crematory 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Servi Lio nsee 22. Name and Address of Facility 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List may one cause on each line. Approximate
Interval Between
Onset and Death
T D A S Immediate Cause (Final Ph_sician/ PAILURE ACUTE RENAL disease or condition Medical resulting in death) Examiner DAY HYPOTENSION Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last as the burial Physician/Medical Box 68760 IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, SUBSTANCE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 🖔 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 X No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М hours after death. Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide determined 24 hours after E Funeral Directleted filled in b Medical 29a. Certifier LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

My

VISHAL VASAVADA

31. Date filed (Month, Day, Year) 32 Registrar's Signature

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MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License numbe

SOUTH HAMOVER STREET

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29d. Date signed (Month, Day, Year)

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BALTIM ORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Diane M. Lynch Mar o 9 12263 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Somariten Hospital Baltin ore 8. Date of Birth (Month, Day, Year) Sept 29, 1961 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Hours Country) unk Director 219-82-5286 50 Sept Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3101 Westfield Ave. 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? unk 1 Yes 2 No 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 - Widowed 4 - Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print)

John Amster - brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3512A Beech Ave; Baltimore, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify) in State cemetery, crematory or other place, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Respiratory Acute disease or condition Medical resulting in death) Examiner nterstitial Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Preumenia Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Pregnant at time of death Day 1 ☐ Yes 2 ♥ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failuxe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Yes 2 V 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 Tes မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar 011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Raven Blvd

03,09,2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 ol Z 12 50 AM Joseph Liberto James March Medical RAITIM OR E 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town 4c. County of Death HOSPITAL AGNES SAINT Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 **X** M 2 □ F Hours 3 (Manth./Day3 Year) 68 MaryTand Director 219-40-5723 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Linthicum 1 Yes 2X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 407 Homewood Rd. 21090 USA items 2 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ö 1 Never Married 2 XMarried 1 ☐ Yes 2 X No If Yes, Give Year or Dates. ρ Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Restaurant 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Liberto Geneva Lascola 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Liberto (Wife) 407 Homewood Rd., Linthicum, MD 21090 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baffilmore Crematory Company of Cherchage Loudon Park 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/19/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee Loudon Park Funeral Home 22. Name and Address of Facility 3620 Wilkens Ave., Blatimore, MD 21229 23a Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Rena stage disease or condition ears Medical resulting in death) Examiner hosis Cars quer tially flat condition Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events executed PO cerrs the attending physician and the for use as the burial-tran Due to (or as a consequence of) resulting in death) Last that the death certificate be Disease cars Corona 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? burs after death.

eral Director: After this certificate Pfilled in by the funeral director, page Yes 2 No 1 Yes 2 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 2 No 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) MD 0069177 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 Baltimore MD MOHAMMAD 900 CATON AVe

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

1 9 2012

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Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Valris March 2012 Moss 1310 P ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2427Lakeview Avenue Baltimore NA Social Security Number 8. Date of Birth (Month, Day, Year) 02-17-56 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🏝 F Days 56 **Director** 214-62-8388 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 USA 2427 Lakeview Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify: American "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic 12th Grade marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Tillman Tillman, Sr. Dorothy Mae Roosevelt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20724South Carol Street Laurel, Maryland Amblear Hart-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 03-20-12 Lansdowne, MD Zion Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. Gilmor Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition hours Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial∹ Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
 5 Other (specify) Month Year Pregnant at time of death Dav Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performs Yes 2 N 1 Tes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Lee

MAR 1 9 2012

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # Lob Per ANA BD G925 3/19/2012 JH State of Maryland / Department of Health and Mental Hygiene 08436 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2ÖÏ2 March 7:00 Brian Gerard McFarland PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 3015 Garrett Rd. White Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov 5, 1958 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min 215-48-9184 Maryland Director 53 1 X M 2 □ F 28a-f show 10a. State 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2x No White Hall MD Harford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **IISA** 3015 Garrett Rd. 21161 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No 1976-Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: white 3 Widowed 4 Divorced Completed 1977 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) 12 MD Dept. of Enviroment College (1-4 or 5+) water plant supervisor MD Dot and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Philip McFarland Carol Ann Boughan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Colleen Husemann - sister e 1 and 2 s 3712 Woodsdale Rd; Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board irector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear Vailure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ CANCIR ESOPHA6 3 AC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Exam that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): /Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant Physician/ 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 - 10 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural 5 Pending ours after death.

eral Director: Aft 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral C Medical 29a. Certifier 1 🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) PHYSTLEAM 00058475 MARKET 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHELEPNEUATPUMEU 510 UPPIENCHTIS APISHOTE DRZUG, BRUNZEMD 21014 31. Date filed (Month, Day, Year) MAR 1 9 2012

Registrar DHMH 17 Rev 06-2011

Baltimore.

68760

Box

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John S. Month 03 13 2012 Medical Macci 06:00 am 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore . Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Hours **Director** 216-24-1967 0971971929 1 X M 2 🗆 F 82 28a-f shov 10a. State 10b. County must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral is marked other than "natural", or items 23a <u>1805</u> Wadsworth Wav 21239 S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 1052 5 11. Marital Status Examiner Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Black, White, etc. within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No 3 X Widowed 4 Divorced Completed r Yes, Give Year or Dates.1952-53 Specify White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry 00:9 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4 or 5+) Machinist Maryland Brush Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 2012 Alfredo Macci Anna Frasca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lisa A. Macci, Dtr. 1805 Wadsworth Way, Baltimore, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MARCH 4 Donation 5 Other (Specify) Gardens of Faith 03/19/2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, 5305 Harford Road, Baltimore, MD'21214 standua 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) မ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural
Acciden
Suicide 5 Pending injury ours after death.

leral Director; Al
filled in by the fi Accident Investigation М 1 Tes 2 No 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completely f 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

TRACIE L.

31. Date filed (Month, Day, Year)

MORGAN.

1 9 2012

CRNP

32. Registrar's

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, 105, 11, 12, 15-18, 20a-c&22peffff, G925, 30/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:51 AM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death altinore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months Min. February Pay, Yan 57 Country)unk **Director** 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 642 Gutman Ave. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? unk

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status - unk 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation—HTR (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 unk Disabled 5 4 1 N/A Be 17. Father's Name (First, Middle, Last) -unk-18. Mother's Name (First, Middle, Maiden Surname) unk မ William Augustus McIntyre Johnnie Mae Worth permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4901 \ \ York \ \ Rd; \ \ Baltimore, \ \ MD \ \ \ 21212$ Johnny McIntyre - brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Greenmount Cemetery Baltimore, MD any injury 4 Donation 5 Other (Specify) - in 3-20-2012 Sign ture of the eral Service Line March Funeral Home Last Baltimore. MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last and -trans Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 9 Unknowń Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) the funeral director Hospital: 2200 Other: 1 Yes မ patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **≯** Natural injury work? 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Pkica 8A. Pa 32. Registrar's Sig State

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DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia		Robin McLaurin		Month March	_	2012	3. Time of E 5:01	eath AM
	Medic Examir			wn, or Location of Death	iiaz en	4c. County		1 3.01	**
-sh			6662 Robins Ct; Apt 87C Gle	n Burnie			ne Arı	undel	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1. Months 579-86-8176 1 Months 52 Yrs.	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day) June 27	Year) 1959	9. Birthp Count <b>Mar</b>	lace (State or try) yland	Foreign
	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				11	0d. Inside City	Limits
	tarylar 3a-f s iffied	Director	MD Anne Arundel Glen Burnie					1 🗆 Yes	
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ylan	should be file h and Mental   7 is marked c raumatic eve	2	John McLaurin	Louise	Smith				
, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print)  Deirdre Outlaw – daughter  19b. Mailing Address (Si 3018 Oran	treet and Number or Ryrangeman Sq #D	il Route Number, ); Waldo	city or Town, S rf, Mar	State, Zip C yland	i 20602	
Baltimore, Maryland 21215-0036	permit. Page 1 al Department of H Important: If itel any injury or oth		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify) in state		Date	20c. Location	- City or Tov	wn, State	
Balt	permit. Depart Import any inj			Address of Facility St. Baltimore				21201	
	hysician/ Medical Examiner		23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Coron Gray Thru		or respiratory arre	est,		Approximate Interval Betw Onset and D	een eeth eeth
09	cate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, it is that the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to or as a consequence of:  Car Diomy of attribute to or as a consequence of:  Due to (or as a consequence of):	y					
Box 687	death certifi ne attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ Other (specil pregnant at time of death 5 ☐ O				ate of deliver	ry Day Ye	ar
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_	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director,	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the	opinion, death occurred at	the time, date an	d place, and du	e to the caus	se(s) and manr	er stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year LUCILLE REITER NASS Medical MARCH 2012 45P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. **Director** 143-24-0690 1 🗆 M 2 🛛 F 79 12/04/1932 DC sho 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD BALTIMORE 1 🗌 Yes 2 🔀 No LUTHERVILLE 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be by Funeral items 23a 7 KILGLASS COURT 21093 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 X Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATOR TOWSON UNIVERSITY marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **EMANUEL** REITER DOROTHY LEWIS ary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trai SABRINA FRIEDMAN / DAUGHTER 9 KILLALA COURT, LUTHERVILLE, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CREMATION, INC 03/15/2012 HAMPSTEAD, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions cause. Enter Underlying Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician Physician/Medical death certificate be Box 68760 as the I IF FEMALE: use a 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Live Birth Z .... Pregnant at time of death for Year Unknown Unknown P.O. Hospital or Attending Physician: The law requires that the β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I d be del 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ၉ Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? n 24 hours after death.

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bletely filled in by the fu 1 Yes Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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completely (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person 🕍 death (Item 23a) (Type, Print)

State Registrar

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year March 2107 <u>Ambaben C. Patel</u> Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Huspital of Baltimore Baltimure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours **Director** 213-55-6274 1 □ M 2 🔀 F 81 6/8/30 India 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Owings Mills known as Ambaben Patel ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21117 USA 214 Berry Vine Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian "natural", or Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 TNo Specify: 3 Midowed 4 Divorced Indian Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Jonee. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kashibhai G. Patel Dhuriben K. Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Berry Vine Dr. Owings Mills, Maryland 21117 Dilip Patel Satient 20a. Method of Disposition 20b. Place of Disposition (Name of Balmer Imore or Oremateory Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) @ Loudon Park 3/17/12 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ 1 gard Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner 20 years atheroscientic heart Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year ours after death.

eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached it 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗹 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) RES-000 March 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lymar, MD Sinch Muspited of Baltimore 32. Registrar's Signature State 1 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A-12 2012 ANNIE Medical 5 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMOR MDOR BALTIMORE VINCO Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** 1 M 2 WF Days Hours Country (Month Day Year) 07/18/1910 0 **Director** Usual Residence of Decedent 28a-f show 10a. State ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE GLEN ARM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4422 LANGTRY DRIVE 21057 USA or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, r than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc ğ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 ♥ Widowed 4 Divorced WHITE 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' U.S. ARMY College (1-4 or 5+) Elementary/Seconday (0-12) SECRETARY CORPS OF ENGINEERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMILEL O'MELL other traumatic SARAH BERNSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANLEY RUBENSTEIN/SON KINGSTREE ROAD, #103, BALTIMORE, MD Baltimore, Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION INC. 03/16/2012 HAMPSTEAD, MD Signature of Funeral Service Lipen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phylician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last and trar Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 the attending phy IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Year Pregnant at time of death Unknown g Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an has autopsy prior to completion of cause of death? page this certificate 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation

Division of Vital Records, Hospital or Attending

State Registrar

Medical

Suicide

4 Homicide

29a. Certifier

(Check only one) 29b. Signature and title of certifie

6 Could not be

determined

completed cause of death (Item 23a) (Type, Print) SK Ba 31. Date filed (Month, Day, Year,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10686

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number

2012

City or Town, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 08443 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ida Elaine Robinson MARCH 14:02 PM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Simor Hospital of Baltinara N/A Baltimore 5. Social Security Number 215-30-8093 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 1 M 2 KF 10/20/1934 77 Maryland or 28a-f show notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1x Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number ō 10f. Zip Code ms 23a or 10g. Citizen of What Country? Funeral 5516 Groveland Ave. U.S.A. 21215 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. 72 hours after 1 Yes 2 No Specify. Specify: Black 3 XWidowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Baltimore City (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) School Public Schools Teacher years Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Page Marie Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duncan S. Robinson (son) 3233 Conservancy Dr., Chesapeake, VA 23323 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗀 Removal from State on-site Crematory03/16/12 |Baltimore,MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fun ral Service License 30sepHddff.offBffown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Retractery,
Due to (or as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Drin to for as a consequence of attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months? Month Day Year 1 Tes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed teeper, raidnetrequi Aprica, certificate ve neart bailing 1 Yes 2. No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBB3 March 14,2012 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co Sinci Hospital of Baltingre 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

ROBINSON

IDA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:50 AM С. Sme1ser Mary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Medical Center Anne Arundel <u>Glen Burnie</u> Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 😿 F (Month, Day, Y. 1011) Director 219-26-9521 July 1940 Maryland Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits notified 1 Yes 2 No Maryland Anne Arundel Pasadena ö 10e. Street and Numbe 10f. Zip Code be 10g. Citizen of What Country? items 23a oner must be 1919 Hilltop Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Wh<u>ite</u> 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene.
27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Landis Thompson Mary Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tr Theresa L. Smelser (Daughter) 758 203rd Street Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 03/20/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. ,22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee MOO-732 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ultiple Sequentially list conditions, Examine if any, leading to mime late cause. Enter Underlying Cause (Disease or iinjury that initiated events to (of ap a con Soutience on attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for Day Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 Yes 2 No funeral director, 25. Was case referred to nedical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ပ္ 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 [ only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

20 v

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

2. Registrar's Sign ture

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type o	Print i	n Black lı	ndelible Ink	k. Ensure	All Copie	s Are Le	gible.	
			For State	State	of Maryl		artment of H		d Mental Hy	/giene	2 272	00115
			Registrar  1. Decedent's Name (First, Middle, I	l ast)		Cei	rtificate of E	Death	2. Date of De	Reg. No. 2	112	08445
7	Physicia Media		NANCY L	SC					Months 3	Day	2012	3. Time of Death 0700 M
	Examir	er	4a. Facility Name (if not institution, g		mber)		4b. City, Town, or	Location of De	ath	4c. Count	y of Death	
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	Director		216-28-1889	1 □ M 2 🗹 F	80	Yrs.	Months Days	Hours M	Dec. 1	ay, Year) 5,1931	Mary.	y)
	land show d at	5	Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Lo	cation				10	d. Inside City Limits
	ne Marylar or 28a-f st notified	rect	Maryland Anne	Arunde1	A	nnapoli.	S					1 🗆 Yes 2 🗷 No
	÷ 0 0	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Countr	ry?
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	ge 1 and 2 should be filed within 72 hour to f Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical		James P. Schell	, ,,, -,	)		ng Address (Street a Edgewood					_{ode)} y1and 21403
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Baltimore,	Page tment tant: I jury o		1 ■ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	□ Removal from ecify)	State	edar Hi	11 Cemete	ry 03/	16/2012	Brookly	n Parl	k, Maryland
Bal	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Lice	Musi	MOO-73	$\frac{22}{M}$	Name and Address Cully-Po 204 Mount	s of Facility lyniak ain Roa	Funeral I	Home, P.	A.	21122
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	- =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conse	equence of):	, , , , , ,					1 (11/0)
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68760	ificate ng phy as the	Medi	IF FEMALE:	u.		_						
9 X	th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 F	etal death 3	Ectopic pregnancy	/			te of delivery	
Box	he dea y the a tched f	Physician/Medical	1  Yes 2 No 9  Unknown	4 ∐ Preg g ☐ Unkr	nant at time o	of death 5 ∟	Other (specify)			Mo	onth D	ay Year
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rds,	equire een si	eted	Pruh CVA, F	EEDING	y (VII)	312			. 1 🗆	Yes 2 No	3 🗌 Proba	bly 4 🗆 Unknown
Division of Vital Records,	e law r has b ge 2 s	Completed by	CAP	REATSI					24a. Was auto	psy		y findings available oletion of cause of
E B	sician: The law certificate has t lirector, page 2 s	Be Co	25. Was case referred to medical	<del></del>			26 Pla	ce of Death (Ch	1 🗆 Yes		1 Yes 2	□ No
Vita	Physicia this cert al direct	욘	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatien	Othor		Home 5 Resid	dence 6 Oth	er Speling	HOSPICE
n of	Jing Ph		27. Manner of Death  1 Natural 5 Pending		of injury th, Day, Year)	28b. Time of injury	28c. İnjury work?		28d. Describe h	now injury occurr	ed	HOUSE
sioi	Attendary r death	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 290 Bloom	of Injury - At	home, farm, stre	et, factory, office	∕es 2 □ No	28f Location (5	Street and Number	ar or Pumi Pi	outo Number
Div	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied.			bullali	ng, etc. (Spec				City or Tou	vn, State)		
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Examonly one) 3 Certifying No.	miner: On the bas	is of examinat	ion and/or investi	ccurred at the time, gation, in my opinior death occurred at the	<ol> <li>death occurre</li> </ol>	d at the time, date a	ind place, and due	e to the cause	e(s) and manner stated
	with Cor		29b, Signature and title of certifier	Lew	taum		29c. License		8	29d. Date signed Mar	Month, Da	y, Year) 222012
	101		39 Name and address of person who	C. PIEN	DA IN	O VILLE	1) LOCK N	ISE H	45 HW A4	ANNAL	ous 1	22012 MDU401
	Stat Registra	_	1. Date filed (Month, Day, Year)	12 /2:1	egistrar's Sigr	ature Au	12					
DHN	//H 17 Rev 06-2		MAK T 3 50	16 Alexander	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2<u>012</u> Month March Μ. Sass Jean 5:50 P M 16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Gilchrist Hospice Center Towson Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 212-30-5318 Hours Director 1 M 2 XF 77 September 13,1934 Maryland Usual Residence of Decedent show 10a. State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Baltimore 1X Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 510 South Oldham Street 21224 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or i þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced Completed Specify: White Year or Dates ed other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 years Hostess / Waitress Restaurant Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ပ Marion Der Delacruz Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Bauer son 111 Old Maple Court, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 20 ± 5 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department Important: If any injury or 4 Donation 5 Other (Specify) Oak Lawn Cemetery Dundalk, Maryland 2012 21. Signature of Fineral Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 MO1176 t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. 23a, Parl Interval Between Onset and Death mediate Cause (Final Ph_{si}in auce 2 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Exam use as the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year isigned by the at Id be detached for Pregnant at time of death Day g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? perform Yes 2 No 2 No 1 🗌 Yes hin 24 hours after death.

the Funeral Director: After this certifice

mpletely filled in by the funeral director, I Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Y Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation M 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge d within 2 To the I only one ord at the time, date and plane, and due to the cause(s) and manner as state Signature 1 29d. Date signed (Month, Day, Year) 18215000 Name and address of person who completed cause of death (Item 23a) (Type, Print) St. \$4105 Baltinere, Shaheen, 6701 N. Charles MAR 1 9 201

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year Xanthippe Siskos 12. March 5:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8208 Cindy Lane Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y July 12, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Year) 932 1 M 2 X F Hours Min. 125-26-9694 New York **Director** 79 Yrs. Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 🛣 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8208 Cindy Lane 20817 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian à 1 Never Married 2 Married Black, White, etc. Yes Yes, Give 2XX No 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stavros Mavricos Fotica Djahilis Stylianos Mavricos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Siskos / Daughter 125 Opossum Hill Road, Aspers, PA 17304 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 14 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Resthaven Crematory 4 Donation 5 Other (Specify) Frederick, Maryland 2012 21. Signature of Funeral Service Licensee Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or wart failure. Inst only one cause on each line. Approximate Interval Between 2 months Immediate Cause (Final Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No for Day Year the 1 ☐ Yes 2 및 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 🗌 No Yes 2 K No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5  $\square$  Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 51616 March 14, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 5454 Wisconsin Ave. #1300, Bethesda, MD 20815 Nelson Kalil, M.D.

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registra s Signa re

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gloria Elaine Soto-Bedingfield 2012 March 9:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4100 N. Charles St; Unit 901 Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year)
Oct 7, 1928 **Director** 533-26-8994 1 □ M 2 🛛 F 83 Washington DC Yrs Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10c. City. Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No MD Baltimore 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 21218 USA 4100 N. Charles St; Unit 901 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. white þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) federal government 12 administrative analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bertha Savage Henry Leo Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 N. Charles St Unit 901; Baltimore, MD 21218 David Bedingfield - husband item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Pheral Service Lic Ronal 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ran Medical Due lo (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examin the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate has 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ည ER/Outpatient 3 DOA 1 Inpatient 2 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certificate: 28c, Injury at injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending death. Accident Investigation 24 hours at er deat Funeral Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year 2 State 2012 Registrar

			Please Type or Print in Bla amend #19a&b Per, ANA BD,	ck Indelible Ink. Ensure . G925, 3/19/2012JH	All Copies Ar	e Legible.
			Please Type or Print in Bla amend #19a&b Per ANA BD tate of Maryand/ AMEND ITEM#20a-	Department of Health and -c,22perFH,6926,4/20/ Certificate of Death	Mental Hygien	ne 2012 081.1.0
	Dhysisia	-/	Decedent's Name (First, Middle, Last)	or model or boarn	2. Date of Death	3. Time of Death
	Physicia Medi	cal	Robert Smith			2012 Year 5:02 A M
No. of	Examir	ier	4a. Facility Name (if not institution, give street and number)  Bowie Health Care Center	4b. City, Town, or Location of Death  Bowie		c. County of Death Prince Geroge's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year,	Birthplace (State or Foreign
			Usual Residence of Decedent	Yrs.	Dec 25, 19	
	aryland a-f sho fied at	Director	10a. State 10b. County 10c. City, Tox Prince George's Bow	wn or Location Tie		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the Mis 23a or 28	Funeral Dire	10e. Street and Number 12120 Wilmont Turn	10f. Zip Code 21721		Citizen of What Country?
9800	e filed within 72 hours after death with the Maryland ttal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status  1 🖾 Never Married 2 🗆 Married  3 🗀 Widowed 4 🗆 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 🗀 Yes 2 🗘 No lift Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1  Yes 2  No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: black
15-(	72 hou n "nati Aedica	nple	(Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b.	Kind of Business/Industry
212	ed within Hygiene. other tha ent, the N		Elementary/Secondary (0-12) College (1-4 or 5+) unk unk	disabled		none
Baltimore, Maryland 21215-0036	should be filed to and Mental Hyg r is marked oth raumatic event.	To Be	17. Father's Name (First, Middle, Last) unk	18. Mother's Nar	ne (First, Middle, Maide	n Surname) unk
, Mar	ge 1 and 2 should be it of Health and Mer If item 27 is marks or other traumatic		19a. Interfry Variable Brown sister Gatherine Brown sister	b. Mailing Ad <b>Bernit leng</b> d Number or Ru 1814 <del>Benign</del> Rd Apt	ral Route Number, City o 8; Washingt	or Town, State, Zip Code) ton, DC 20002
nore	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t		1 Burial 2 X Cremation 3 Removal from State cemet	of Disposition (Name of ery, crematory or other place)		Location - City or Town, State
altin	permit. Pa Departme Importan any injury once.	ľ	21. Signature of Funeral Service Licensee	22. Name <b>Pringenia Film</b>		tsville, MD
Ω	e a E c		Jun //	9013"Annapolis"R	d. Lanham,	MD 20706 ²¹²⁰¹
ı,	h sisian/		23a. Part Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onser and Death
	Ph sician/ Medical	Ĥ	disease or condition resulting in death)  myocardial information at the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the co			1 nour
	Examiner	er	Sequentially list conditions, if any, leading to immediate b. hypertension Due to for as a consequence			5 years
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	OI).		
	oe executed ician and burial-transit	ᄝ	resulting in death) Last  Due to (or as a consequence	of):		
68760	ficate by g physias the l	Medic	d			
. Box 68	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physici stely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	<b>~</b> I	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery Month Day Year
P.O.	that the	by Pr	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of death?
rds,	equires een sig nould b	eted	seizure disorder		1 🗆 Yes	2 No 3 ☐ Probably 4 ☐ Unknown
Records,	e has bage 2 sl	Completed by			24a. Was an autopsy performe <u>d</u> ?	24b. Were autopsy findings available prior to completion of cause of death?
a H	sician: The law is certificate has build irector, page 2 s		25. Was case referred to medical examiner?	26. Place of Death (Chec	performed?  1  Yes 2 X 1  ck only one)	No 1 Yes 2 No
₹ Zit	Physic this ce ral dire	ျှ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/O		ome 5 🗆 Residence	
o uc	nding ath. r: After ne fune	icate	77	Time of injury at work?  M 28c. Injury at work?  1 □ Yes 2 □ No	28d. Describe how inju	iry occurred
Division of Vital	To the Hospital or Attending Physician: The la within 24 hours after death.  76 the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fi building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
_	Hospita 24 hours Funeral stely filled	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/	or investigation, in my opinion, death occurred a	at the time, date and place	e, and due to the cause(s) and manner stated.
:	To the		only one) 3 ☐ Certifying Nurse Practitioner: To the best of my kno 29b. Signature and title of certifier	owledge, death occurred at the time, date and p  29c. License number	ace, and due to the caus	se(s) and manner as stated.
	(2)		I feter B. Sherer mo	021910	M	ate signed (Month, Day, Year) arch 6, 2012
			30. Name and address of person who completed cause of death (Item 23a)  Peter Sherer 3921 Ferrara Dr; Wh			-
	Stat	6	31. Date filed (Month, Day, Year) 32 Registrar's Sign ture			
	Registra	r	MAR 1 9 2012 Sengua 18. 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per PHY G925 3/19/2012 JH. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		_	Foi	Certificate of Death		Reg. No.	0.001.50
	Physicia		1. Decedent's Name (First, Middle, Last)  Arnetta Nancy Shearn		2. Date of Dea	13 ^{Day} 2012	3. Time of Death U
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Dea	
	e e		5257 Darien Rd.  5. Social Security Number 2 6. Sex 7. Age (In yrs. last birth	Baltimore  Iday)   If Under 1 Year   If Under 24 Hr	S. 8. Date of Birt	N/A	thplace (State or Foreign
	Funeral Director		214-40-1019 1 M 2XF 68	Months Days Hours Mir	n. (Month, Da	/1943 Mar	ountry)
	show at	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		7 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1	10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD N/A Ba	altimore			1 🙀 Yes 2 □ No
	ith the	ral Di	10e. Street and Number 5257 Darien Rd.	10f. Zip Code 21206		10g. Citizen of What C	ountry?
	eath w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	U.S.A.	erican Indian,
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes, 3 Widowed 4 Norried 1 Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Pue  1  Yes 2 No Specify:	rto Rican, etc.)	Specify: B1	e, etc.
15-(	72 hou n "nat Aedica	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking	Baltimore	Industry City
212	within giene. er thar t, the M			stodian Supervis	or	Public S	chools
Maryland	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last)		ame (First, Middle,	·	
يَّر	should be and Menta		Leonard Bolden  19a. Informant's Name/Relationship (Type, Print)  19b.	Mailing Address (Street and Number or F	etta Gi		in Code)
, M	and 2 sh Health ar tem 27 is			257 Darien Rd.,			
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of cemeters	Disposition (Name of y, crematory or other place) te Crematory (33/	Date	20c. Location - City o	r Town, State
Balt	permit. Departi Import any inji		21. Signature of Funeral Service Licensee William	Joseph H. Brown 12140 N. Fulton			
Ľ	*		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate Interval Between
, start a	Medical			ATTC BREAS	T CA.	NCER	Onset and Death One year
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	p is	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	f):			
	ificate be executed g physician and as the burial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	f);			
0	e be ey ysician e buria	<b>dedical</b>	d				_
8760	rtificate ing phy e as th	/Med	IF FEMALE:				
Box 68	law requires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death  4 ☐ Pregnant at time of death	3  Ectopic pregnancy 5  Other (specify)		23d. Date of de Month	Day Year
s, P.O.	ires that th signed by Id be detac	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		obacco use contribute t	o the cause of death?  Probably 4 Unknown
iord	S S S	Completed			24a. Was		utopsy findings available completion of cause of
Re	The law cate has page 2					rmed? death?	s 2 🗆 No
ital	sician: The certificate irector, paq	) Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Incatient 2 FR/Out	26. Place of Death (Ch			
Division of Vital Records,	Attending Physician: The sr death. ector: After this certificate I by the funeral director, pag	cate: To	27. Manner of Death 28a. Date of injury 28b. Ti			dence 6 Other (Spe	cify)
Divisio	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fan building, etc. (Specify)	m, street, factory, office	28f. Location (S City or Tow	Street and Number or Runn, State)	ıral Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, or 2 Medical Examiner: On the basis of examination and/or 3 Certifying Nurse Practitioner: To the best of my know	investigation, in my opinion, death occurred	d at the time, date a	nd place, and due to the	cause(s) and manner stated.
_	To the	-	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	h, Day, Year)
J	}		30. Name and address of person who completed cause of death (Item 23a) (T	D005886		03/16/2012	
			SHAWN DHILLON MD 333	33 N. CALVERT.	ST. Suit	18555 BALL	218.
£	Sta Registra	te ar	31. Date filed (Month, Day, Year) 6 2012 32. Jegistrar's Signature	Bares			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma	ryland / Depa	artment of He tificate of De			0.0	10 00151
			1. Decedent's Name (First, Middle, Last)	Cer	unicale of De	eauri	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia		Mary Ellen Ashton				Februar	y 29, 20	
and the same	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo			4c. County of	
أممية	<i>3</i>		3600 Dunlop Street		Chevy Ch		0.0.1.1011		gomery
\$	Funeral Director		5. Social Security Number 6. Sex 7. Age 1	(In yrs. last birthday) 61 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	/, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent				Jan. 19	, 1951	LA
	yland f sho ed at	ctor		10c. City, Town or Loc					10d. Inside City Limits  1  Yes 2  No
	e Mar r 28a notifi	Director	Maryland Montgomery  10e. Street and Number	Kensingto	10f. Zip Code	-		10g. Citizen of W	
	with th		4125 Warner Street		20895			USA	nat Godiniy.
	tems remu	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No-	14. Race	- American Indian,
36	after d I", or i camin	þ	1 Never Married 2 X Married 1 Yes 2 X N	_	Yes 2 No				White, etc.
9	atura cal Ex	Completed	3 ☐ Widowed 4 ☐ Divorced		ent's Usual Occupati		- Indian	16b. Kind of Bu	
215	in 72 t e. nan "n Medi	ldmc	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+	U.S. D.C	aind of work done dur O NOT use retired)	ing most of worki	ng	, , , , , , , , , , , , , , , , , , , ,	,
2	d with lygien ther th	ക	6	Teac				Educat	lon
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, Middle, Last)  Jaime Acevedo Navas		1	8. Mother's Name Mary Mo		,	
ary	and Me		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and	d Number or Rura	I Route Number	; City or Town, St	ate, Zip Code)
Σ	nd 2 sl salth a n 27 i		Robert Kendall Ashton / Hus	band 4125	Warner St	reet, Ke	nsingto	on, MD 20	0895
ore	t of Har of Hitel		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State		natory or other place)				City or Town, State
Iti m	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Significant Service Wensee	Metropolit					cia, Virginia
Ba	Depar Depar Impor any in		Nichard L Hater	Fi	Name and Address ancis J. 00 Univers	Collins ity Blvd	Funeral	Home, Silver	Inc. Spring, MD 20901
			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.	he death. Do not ente	r the mode of dying,	such as cardiac o	r respiratory arr	est,	Approximate Interval Between
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  Metastat  a. Due to (present)	ic Breast	Cancer To	Brain			Onset and Death yr. 2 mos.
	Examiner		Due to (or as a t	consequence of): lateral Br	east Canc	er			2 yrs. 4 mos.
		iner	Sequentially list conditions. b.	contaquanta ci):					
	cuted	xam	Cause (Disease or injury that initiated events c.	consequence of):					
_	icate be executed is the buriefunction	edical Examine	resulting in death) Last Due to (or as a d	sonsequence or,					
3760	ficate g phys as the		d						
Box 68	r certi	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of 1 Live Birth 2		Ectopic pregnancy				e of delivery
Bo	nat the death certific ed by the attending p detached for use as	Physician/M	1 ☐ Yes 2 ဩNo 4 ☐ Pregnant at t 9 ☐ Unknown 9 ☐ Unknown	ime of death 5	Other (specify)			Mon	th Day Year
Division of Vital Records, P.O.	hat the ed by detac	by Ph	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause giver	n in Part I.	23e. Did to	bacco use contri	oute to the cause of death?
JS, I	requires that been signed should be det						1 🗆 🕻	res 2₺ No	3 ☐ Probably 4 ☐ Unknown
Sorc	aw reg as bee 2 sho	Completed					24a. Was a	sy pi	ere autopsy findings available rior to completion of cause of
Re	sician: The law certificate has t						1 Yes		eath?
ital	sician certifi irector	m	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No		Other	e of Death (Check		- [7/*	(Specify) Residence
of V	uing Physician: n. After this certific funeral director,	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury a			ence 6 AOther	Opecity
ono	ending sath. or: Aftu	ficat	1   Natural 5 □ Pending (Month, Day, 2 □ Accident Investigation	Year) injury	work? M 1 □ Ye	es 2 🗆 No			
Visi	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	r - At home, farm, stre (Specify)	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, death o	ccurred at the time, of	date and place, an	d due to the ca	use(s) and manne	r as stated.
	he Ho in 24 h he Fu	Medical	(Check 2 Medical Examiner: On the basis of exaconly one) 3 Certifying Nurse Practitioner: To the	mination and/or investi pest of my knowledge,	igation, in my opinion, death occurred at the	death occurred at time, date and pla	the time, date a ce, and due to ti	nd place, and due ne cause(s) and ma	to the cause(s) and manner stated. anner as stated.
	-		29b. Squature and title of certifier	1. N.	) 29c. License no D37236			29d. Date signed March 1	(Month, Day, Year) 2012
	12		30. Name and address of person who completed cause of dea	th (Item 23a) (Type P	/				-
			Carolyn B. Hendricks, MD 64	10 Rockled	lge Drive	#506, Be	thesda	MD 208	17
	Stat Registra		31. Date filed (Month, Day, Year)  NAR 0 2 2012	s Signature	2				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012Andreotti John R. March 2:30 a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice - Casey House Montgomery Rockville . Age (In yrs. last birthday) Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 🔀 M 2 🗆 F Months Days Hours Min. Feb 21, 1931 131-22-1375 81 NY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 15312 Aylesbury Street 20905 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Electrical Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Primo Andreotti Filomena Piracci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ute Andreotti / Wife 15312 Aylesbury Street Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 5. 1 E Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2012 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate Cancer disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a, Was an autopsy performed? Yes 2 X N

Hospice

29d. Date signed (Month, Day, Year)

March 3, 2012

Medical Examiner Burial-transit executed attending physician that the death certificate be Division of Vital Records, P.O. Box 68760 as the asn for the detached ģ signed b page 2 should Jas or Attending Physician: The certificate l the funeral director. After this death. within 24 hours after deatl To the Funeral Director. filled in by the Hospital

Physician/Medical

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Completed

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Certificate:

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29b. Signatura

Physician/

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10a. State

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Examiner

**Funeral** 

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1 and 2 should be file of Health and Mental H item 27 is marked o

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Department of Important: If it any injury or o once.

Physician/

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traumatic event, the

within 72 hours after

Baltimore, Maryland 21215-0036

Examiner

ms 23a or 28a-f sho must be notified at

Director

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Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Cause (Disease or in that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 XNO 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No M ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ only one

State Registrar

peted

Geoffrey Coleman, 1355 Piccard Drive Suite 100 Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

d title of certifie

29c. License number

D37142

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav GILBERT PETER ADELHARDT ٦ March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Meadows Community Glen Arm Baltimore 5. Social Security Number 6. Sex 1 **M** M 2 □ F If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Birth Months Days Min 215-05-47 95 Director Maryland Usual Residence of Decedent or 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director MD. 1 Yes 2 X No Harford Whiteford 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 4435 Prospect Road 21160 United States or items hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Il Hygiene. other than "natural", 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Tea & Spice College (1-4 or 5+) Plant Superintendent Manufacturer Department of Health and Mental Hy Important: If item 27 is marked other any injury or other trainman. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter George Adelhardt Josephine Kapisak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian J. Adelhardt (Son .0. Box Joseph, Oregon Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of March 19, 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 0ak Lawn Cemetery 2012 Dundalk, Maryland 21. Signature of Funeral Service Uicensee E.G. Kurtz & Son Funeral alden Jarrettsville. Home PP.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 2 No 9 Unknown Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by roselevoto cardiovascular **Hospital or Attending Physician:** The law requires to bours after death. 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No To the Funeral Director: After this certificate of completed filled in by the funeral director, page 1 🗌 Yes 2 🗌 No Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No. Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

March 13, 2017 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St

Registrar

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32. Registrar's ignatur

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Baltimore Ma 21204

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Brian Winifred Buck

2012 08454

			1- For State Registrar	Ce	ertificate of	Death		Re	eg. No.	6 0040
Phy ical Ex	ysicia xami	an/	1. Decedent's Name (First, Middle,Last)  Brian W.	Buck				2. Date of Deat Month February 2	Day Year	3. Time of Death 1456 hrs
			4a. Facility Name (if not institution, give s 12161 Rousby Hall Road		4	b. City, Town, o	or Location of Dea		4c. County of Deal	th
Free		-	5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Ye	ar If Under 24H	rs IR Date of Rin	th (MM/DD/YYYY) 9. Bi	irtholace (State or
Fun Dire			218-80-5898 1XIN		50 Yrs.	Months Da			Fore	
	' any		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location	on				10d. inside City Limits
and	28a-f show i at once.	ы	MD Calver	t	Lusby					1 Yes 2 No
he Maryl	5 2	Director	10e. Street and Number 12516 Olivet	Road		10f. Zip Code 206	57	10	Og. Citizen of What Cou USA	untry?
5 72 hours after death with the Maryland	items 23s	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in Armed Forces?			ispanic Origin? ( s an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
after de	ral", or i	by Fu		1 Yes 2 X No Yes, Give Year or Dates:		Yes 2 🗓 N			Specify: B1a	
hours	Exam		15. Decedent's Education (Specify only Elementary/Secondary (0-12)	highest grade completed)  College (1-4 or 5+)			ation (Give kind of e. DO NOT use re		16b. Kind of Business	/Industry
<b>∞</b> .5 .	er than Medical	Completed	12	College (1-4 or 51)	La	borer			Constru	ction
21215-0036 and be filed within 7 Mental Hygiene.	narked other than "natural", event, the Medical Examiner	Be Co	17. Father's Name (First, Middle, Last) Nathaniel	Buck,	Sr.		18.Mother's Nam Fran	ne (First, Middle, N C e s	Maiden Surname) Stewai	rt
, MD 21215-003( and 2 should be filed within ealth and Mental Hygiene.	Important: If item 27 is marked other ti injury or other traumatic event, the Mec	٤	19a. Informant's Name/Relationship (Typ Violet Cannon/			Address (Stre			ber, City or Town, Stat	e, Zip Code)
more, Pages 1 and nent of Healt	If item ther tra		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	. Place of Disposit crematory or oth	er place)		Date	20c. Location - City o	
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ന് ഉദ് Physic		1114	Blacky U. S. 23a. Part I. Enter the disease, or complic	ations that caused the deat						ome, P.A. ed., MD2067
/Med ≟xami	lical		failure. List only one cause on each Immediate Cause (Final disease a. C			-,,,,,	,,			Between Onset and Death
				ie to (or as a consequence	of):					
		miner	cause. Enter Underlying Cause	ue to (or as a consequence	of):					
peq	nsit	Exam	Cronto resulting in death) Last	e to (or as a consequence	of):					
), be execu	the burial - transit	/Medical	d.	AMENDED						
<b>38760,</b> rtificate be	ing phys as the bi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	2 Feta	al death 3	Ectopic pregr	nancy	23d. Date of deliver Month	ry Day Year
Box 68 death certif	the attending ed for use as	Physiciar	1 Yes 2 No 9 Unknown	4 Pregnant at time of c	death 5 Oth	er (Specify)				
<b>P.O.</b> I that the	signed by the be detached	by P	Part II. Other significant conditions o	ontributing to death but not	resulting in the ur	nderlying cause	given in Part I.		bacco use contribute to	
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cie sa	his certificate director, page	a	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	7		Other Nurs			
of Vi g Physi		일	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of In		ury at Work?	28d. Describe h	Residence 6 🗹 Othe	
Sion (trendin death.	4-	ation	1 Natural 5 Pending 2 Accident Investigation	Feb 25, 2012	1448 hrs		Yes 2 ✓ No		fell on subject wh	
Division of Attendiums after death.	illed in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At (Specify) Woods	home, farm, street	, factory, office	building, etc.	or Town, St		ural Route Number, City  MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: completely filled in by the	edical C	one) 2 Medical Examiner: 0	To the best of my knowle	_				• •	
Tot	Com	Med		nd manner stated.			se number		29d. Date signed (Mo	
			auétz:			0.0	.M.E.		February 26, 20	12
RW 2	)		30. Name and address of person who con Ana Rubio MD. Assistant	mpleted cause of death (Itel		nore Street	, Baltimore. M	ID 21223		
N a		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa						

OGME

Physician/

Medical

**Examiner** 

**Funeral Director** 

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/

Medical Examiner

29a. Certifier

(Check only one 29b. Signature and litle of contifi

Marichu

31. Date filed (Month, Day, Year)

30. Name and advress of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Matas

Director

Completed by Funeral

Be

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	Please							s Are Legible					
For State Registrar		State of Ma	aryiano		artment of t tificate of l		-	giene Reg. No. 2 1 1 2	0 001.55				
	(First, Middle, Last)						2. Date of Dea	ath	3. Time of Death				
Charlie		dbetter	Bry	ant			Februar	cy 28, 2012	02:00 M				
4a. Facility Name (if I			1407			r Location of Deat	'n	4c. County of Death					
5. Social Security Nu	rove Adven			st birthday)	Rockvil If Under 1 Year		Montgomery  8. Date of Birth  9. Birthplace (State or Foreign						
579-58-( Usual Residence of I	19/3	]М 2 🕅 F	82	Yrs.	Months Days	Hours Min.		, Yer 1929	ountry) NC				
10a. State	10b. County		10c. City,	, Town or Loc	ation			-	10d. Inside City Limits				
MD 10e. Street and Num	Prince Ge	orge's	Temp	le Hil					1 ☐ Yes 2X No				
		les Count			10f. Zip Code 20748			10g. Citizen of What C					
11. Marital Status	ephen Pett	12. Was Decedent E	ver in U.S	13 V		ispanic Origin? (Sp	pecify Yes or No-	United Sta					
1 Never Marrie		Armed Forces? 1  Yes 2	No	If	Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	14. Race - Ame Black, Whit	te, etc.				
3 🕅 Widowed 4		If Yes, Give Year or Dates.		1	☐ Yes 2 X No	Specify:		Specify: B1	ack				
(Spec	15. Decedent's Edu ify only highest grade	cation e co <i>mpleted)</i>		(Give k	ent's Usual Occup	ation during most of wor	king	16b. Kind of Business	Industry				
Elementary/Seco	nday (0-12)	College (1-4 or 5-	+)	Caret	NOT use retired)			Home Healt	hanro				
17. Father's Name (F.	irst, Middle, Last)			Caret	aker	18. Mother's Nar	ne (First, Middle,	Maiden Surname)	ncare				
Pau1		Ledbe	tter	, Jr.		Bertha		Roberts	on				
19a. Informant's Nar	ne/Relationship (Type	ə, Print)	-	19b. Mailine	g Address (Street	and Number or Ru	ral Route Number	r, City or Town, State, Zi	p Code)				
	Vooden / D	aughter				Pettko C	t., Temp	ole Hills,	MD 20748				
20a. Method of Dispo 1 ☐ Burial 2 💆	osition 【Cremation 3 ☐ R	temoval from State			sition (Name of natory or other plac	re)	Date	20c. Location - City or	Town, State				
4 Donation	5 Other (Specify)		At1	lantic Crematory 03/01/2012 Glen Burnie, MD									
21. Signature of Fund	a IIII	,	м009	I	Name and Addres <b>hibadeau</b>	Mortuar	y Servic	ce, p.a.					
23a. Part 1. Hiter th	e disease, or complic	cations that caused			r the mode of dyin	<b>enue. (3a</b> g. such as cardiac	ithersbu or respiratory arm	est. MD 208	Approximate				
shock, or heart Immediate Cause (F	failure. List only one	cause on each line.							Interval Between Onset and Death				
disease or condition resulting in death)	a.	Due to (or as a	conseque	ence of):	mary	Here	-54						
Seguantially list own	ditions b	Coron	are	4 AI	tery	Disea	ise						
Sequentially list con- if any, leading to imr cause. Enter Underly	nediate ving	Due to (or as a	conseque	erice of):									
Cause (Disease or iii that initiated events	njury c.	Due to (or as a	Sis	>									
resulting in death) La	ast	Due to for as a	conseque	ince on:	1000	Stage	TIT						
	d.	- cca	0140		····	o inge							
IF FEMALE: 23b. Was decedent p in the past 12 in 1  Yes 2 2 9  Unknown	onths?	Bc. If yes, outcome o 1  Live Birth 2 4  Pregnant at 9  Unknown	Petal	death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year				
Part II. Other signific	cant conditions cont	ributing to death bu	t not resul	Iting in the un	derlying cause giv	en in Part I.		bacco use contribute to	the cause of death?				
Mor	bound bid ob	esity					24a. Was a	an 24b. Were au	topsy findings available completion of cause of				
							autop: perfor	med? death?	s 2 No				
25. Was case referred examiner?	. —	-24-1				ace of Death (Chec							
1 🗆 Yes 2 🗶	No Ho			R/Outpatient		4 ☐ Nursing H	ome 5 Reside	ence 6 Other (Spec	ify)				
27. Manner of Death  1 ★ Natural 5 □ Pending (Month, Day, Year)  2 □ Accident Investigation 3 □ Suicide 6 □ Could not be							28d. Describe how injury occurred 2 □ No						
4 ☐ Homicide	determined	28e. Place of Injury building, etc.	/ - At hom (Specify)	ie, farm, stree	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, Self-contented at the time, date and place, and due to the cause(s) and manner stated.

69148

29d. Date signed (Month, Day, Year)

Molecular Dr Suite 206 Rockville, MD 20850

February 28,2012

29c. License number

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

Registrar DHMH 17 Rev 7/2009

State

10110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Freelon. 28, 2012 Year Boullata Renee 8:45a_M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Emeritus Assisted Living Montgomery Potomac Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 048-54-7176 81 6/9/1930 **Director** 1 □ M 2 🛛 F Palestine Usual Residence of Decedent show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Montgomery Potomac 1 🗌 Yes 2 🔀 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11215 Seven Locks Road 20854 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items? any injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces?

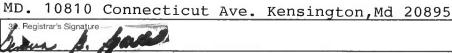
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Boullata Barbara Atalla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5101 River Road #815 Bethesda, Md. 20816 Suad Shammas/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Columbia Gardens 3/2/2012 Arlington, Va. 4 Donation 5 Other (Specify) Signature of Funeral Service PHATERIP Color FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Coronary artery disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Severe mitral reguurgitation Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Severe tricuspid regurgition Due to (or as a consequence of): ttending physician a for use as the burial-Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🕱 No Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, chronic lymphoid, leukemia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It. 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) assisted 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred living 1 Natural 5 Pending iniury work?
1 Yes 2 No U completely filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State

Eirene Koroulakis MD. 31. Date filed (Month, Day, Year)

29b. Signature and title of certified



de 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

D57304

29d. Date signed (Month, Day, Year)

March 1,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Bartholow 201 1020 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Hag Washington roadmore ASSISTERLIVIA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia **Funeral** 8. Date of Birth April 23 1 M 21 Months Min. 213-38-1827 94 Director Usual Residence of Decedent or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 10828 Oak Forest Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Frances Coleman William Armis Coleman permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10828 Oak Forest Drive, Hagerstown, MD 21740 Kathy Passero / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State March 5, Gate of Heaven Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signatural of Funeral Service Live 22. Name and Address of Facility Francis J. Collins Funeral Home, 500 University Blvd., W., Silver Inc. Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) ementio Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown plnous Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Assistant Living examiner? ျှ 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this gampleted filled in by the funeral tuneral to funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending work' 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ath occurred at the time, date and place, and due to the cause(s) and manner as stated.

RO93556

29d. Date signed (Month, Day, Year)

2012

3 Certifying Nurse Practioner: To the best of my knowledge, de-

completed cause of death (Item 23a) (Type, Print) 1124 Opal

82. Registrar's Signature

12-02017 Selvin Baudilio Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Selvin Baddillo	1- For Sta Registrar			tate of Maryl	-		e of De		i wenta		Reg. N	20		2 0845
Physician Medical Examine	.,		e (First, Midd Elvin 1	_{lle,Last)} Baudilio						2. Date of Month March		y Year		3. Time of Death 1115 hrs
, ,				on, give street and n	umber)			y, Town, or L	ocation of D		10, 20	4c. County of	Death	
Funeral	5. Social		mbard St	6. Sex	7. Age (In yrs	last hidhds		timore nder 1 Year	If Under 24	Alles To Date o	f Dieth (M	14/0000000	O Birdh	nplace (State or
Funeral Director	No	one		1 M 2 F		28		nths Days		Min.	24/1	1	Foreign	
Any	10a. State		f Decedent 10b. County		10c. Ci	ty, Town or	Location						Т	10d. Inside City Limits
	Md Md				В	altimo	ore							1 X Yes 2 No
the Maryland n or 28a-f sh tified at ooce	10e. Stree		mber Lombat	+2 ba				Zip Code 1224		·	10g. (	Citizen of Wha		ry?
Baltimore, MD 21215-0036  pemir. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shouling or other traumatic event, the Medical Examiner must be notified at occa-	11. Marita	l Status		12. Was De	cedent Ever in	U.S. 13	3. Was Dece	edent of Hisp		( Specify Yes o			Americ	an Indian, Black,
er death with t	1 Ne		ed 2 X M	Armed F  1 Yes  Vorced If Yes, Give Yes	2 X No					erto Rican, etc.) Ionduras		White,		spanic
ours after	3 7 7			or Dates: ecify only highest gra		16a. Dec	cedent's Usu	al Occupatio	on (Give kind	of work done		Specify: b. Kind of Busi		_
5-0036 ed within 72 hour lygiene. other than "nature the Medical Example Computer and Computer and Computer and Computer and Computer and Computer and Computer and Computer and Computer and Computer and Computer and Comp	Elemen	-	ondary (0-12)	College (	1-4 or 5+)			vorking life. [	DO NOT use	retired)				
d within	17. Father	9th 's Name	(First, Middle	, Last)	-	ال ال	abor	118	3.Mother's N	ame (First, Midd	lle. Maide	Const	truc	tion
1215 I be file ental H rrked o	Jor	_	ejia R					İ	Maria	de los	Ange	eles Ma		
MD 21215-0036 and 2 should be filed within 7 lails and Mental lygiene. m 27 is marked other than aumatic eveot, the Medical				hip (Type, Print ) atamoros/(	Cousin					or Rural Route • Baltin				
Te, N I and I Health Fitem	20a. Meth	od of Dis	position	3 X Removal fr	20b	. Place of D	_	lame of ceme		Date		c. Location - C		
Baltimore, permit. Pages 1 an Department of Hea Importact: Uties injury or other tr	4 Do	nation 5	Other S	ecify:	om State	Genera	al Cem	etery		03/20/1:		Hondu		
Ball permit Depart Impor	21. Signat	ure of Fu	neral Service	Licensee	(mgg	17/2				John T. E Washir				
Physician	23a. Part	. Enter th	e disease or	complications that on each line.	aused the deal	th. Do not er								Approximate Interval Between Onset and
/Medical examiner	Immediate	Cause (	Final disease	a Maligna	nt Ast		oma							Death
	Sequentia			b.	consequence	OT):								10.00
		ding to im nter Unde	mediate rlying Cause	Due to (or as a	consequence	of):								
an transit	events res		hat initiated death) Last	Due to (or as a	consequence	of):								
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8760, ificate be g physici s the burn	IF FEMAL 23b. Was d	ecedent	pregnant in th	23c. If yes,	outcome of pre		Fetal deal	h 3	Ectopic pre	gnancy	2	23d. Date of de	elivery Da	y Year
b. Box 6876 the death certificate by the attending phyched for use as the Physician/M	past 1	2 months		4 Pregr	ant at time of o	leath 5	Other (S	_		gnarcy		WOTH	Da	y rear
O. B. at the de lacked f				lons contributing to		resulting in	the underlyi	ng cause giv	en in Part I.	23e. D	id tobacc	o use contribu	ute to th	e cause of death?
B, P.( irres than signed to be det										_ 1 _	Yes 2	No 3	Proba	bly 4 🗹 Unknown
Records, The law requires freate has been sig	<u> </u>						_				utopsy	pric	or to cor	psy findings available mpletion of cause of
Rec : The lificate I, page		ann rofors	ed to medica						(D. II. (O)	1 <b>✓</b> Ye	erformed es 2		eth? Yes	2 No
Vital vysiciae this cert director	examir	er?	2 No	Hospital:	npatient 2	ER/Outpa	itient 3		de e e	rsing Home 5	Resid	dence 6	Other: §	Scene
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be excepted him 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician an expletely filled in by the funeral director, page 2 should be detached for use as the burial - trans lical Certification: To Be Completed by Physician/Medical E	27 Manne	r of Death		28a. Date (Month	of Injury , Day,Year)	28b. Time	e of Injury	28c. Injury	at Work?	28d. Descri	be how in	njury occurred		
Division o spital or Atteoding sours after death, oeral Director: Aft filled in by the fune Certification:	2 Ac	cident	Inves	stigation	e of Injury - At I	home, farm,	street, facto			28f. Locatio	n (Street	and Number	or Rura	Route Number, City
Divis  Bapital or A  hours after  coeral Dire  y filled in b	4 H	icide micide		mined (Specify)						or Tow	n, State)			
To the Hos within 24 h completely completely		1		nysiclan: To the bes mlner:On the basis	of examination									
	29b. Signa		title of certifie	and manner s	tated.	1		9c. License r				l. Date signed		
2 -	le	U	ll	11	N	1	11	O.C.M.	.E.		Ma	arch 11, 20	)12	
		and addre		who completed caus Assistant Medic		17	V. Baltim	ore Street	, Baltimo	re, MD 2122	23			
State	31. Date fi	ed (Monti	h, Day, Year)	012 % Re	gistrar's Signa	ure	20	-			-	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . 26, John C. Bennett, Jr. February Medical 2012 12:40 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Spa Creek Center Annapolis Anne Arundel cial Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 301-28-9472 Davs 73 **Director XX**M 2 □ F June 29, 1938 Ohio Usual Residence of Decede 28a-f show with the Maryland aţ 10a State 10h Counts Director 10c, City, Town or Location 10d. Inside City Limits Maryland Anne Arundel notified Annapolis 1 Yes 2 X No ō 10e. Street and Number Examiner must be 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1904 Carrollton Road 23a Funeral 21409 items ? permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items amy rigury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced If Yes, Give 1 Yes 2 X No Specify. White Year or Dates. 1957-61 15. Decedent's Education . Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use reti Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer District of Columbia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ John C. Bennett, Sr. Mary Gertrude Hennessey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Carrollton Road Annapolis, Maryland Joan Bennett/wife Annapolis, Maryland 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory 3/5/2012 Baltimore, Maryland 21. Signatural Sirvice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 000 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Ph_sician/ Onset and Death Cerebrovascular Accident disease or condition Medical resulting in death) <u>days</u> Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events years Due to or as a consequence of Exami spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director, After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the bunal-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? death? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yeş 2**X** XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural 5 Pending 2 Accident
3 Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours Medical 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, D21438 February 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 06-2011

Registrar

Michael J. LaPenta, MD

FEB29

31. Date filed (Month, Day, Year)

445 Defense Highway

32. Regis

Annapolis, Maryland

Amend #19B per AA Co. Health			e Type or									_	ible.	
		For State	State	of Marylai			ent of F ete of E		and iv	ientai my	Reg. N	0.0	12	081.60
		Registrar  1. Decedent's Name (First, Middle, L	ast)		00	rinca	ito or L	Joann		2. Date of De	ath		16	3. Time of Death
Physiciar Medica		Thomas Benr	ett						ĺ	Febru	ary	25	Year 2012	8:30 am
Examine		4a. Facility Name (if not institution, gi	ve street and nui	mber)		4b. Cit	y, Town, or	Location				c. County	of Death	
		Heritage Hark 5. Social Security Number 6.		7 4-2 //	In a file back atoms.		napo: ler 1 Year	lis I If Under	v 24 ∐vc	D D-4 4 Di		nne	Arur	
Funeral Director			Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 82	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Jan •	y, Year)	1930	Coun	place (State or Foreign try) rginia
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ا اقبات ا	þ	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 X Married</li> <li>3 ☐ Widowed 4 ☐ Divorced</li> </ul>	Armed Fo	2 <b>X</b> No ve			edent of Hi ecify Cuba 2 XNo			cify Yes or No- Rican, etc.)		Blac	e - Americ k, White, B1 a	etc.
5-0	plet	15. Decedent's (Specify only highest		f)	16a. Dece	dent's Us	ual Occup	ation durina mos	st of workir	na	16b.	Kind of B	usiness/Ind	dustry ates
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	e Completed	Elementary/Secondary (0-12) 8th	College (	1-4 or 5+) 0	life. L	OO NOT u	se retired) Serv	rice			Na	ava1	Aca	demy
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Te, 1 and 1 and of Hea		Barbara Bennet 20a. Method of Disposition	,	20b.	Place of Disp cemetery, cre	osition (N	ame of			Date	20c.	Location -	City or To	own, State
Page Page ant: If ury or		1 $\square$ Burial 2 $X$ Cremation 3 4 $\square$ Donation 5 $\square$ Other (Spe	□ Removal from cify)	n State M	etro				2-29	-12	Ba	alti	more	e, Md.
Baltimore, semit. Page 1 and Department of Hea mportant: If item my injury or other proce.		21. Signature of Funeral Service Lice	nsee	•			and Addres			Mort	מפנו	32 E	2 7	
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Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medica	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 🔲 Live	itcome of pregr Birth 2 Pe gnant at time of nown	tal death 3	Ectopi Other		<b>у</b>					te of deliventh	ery Day Year
P.O that the	by Pł	Part II. Other significant conditions	1		esulting in the	underlyin	g cause giv	ven in Part	t 1.	23e. Did 1	tobacco	use cont	ribute to th	ne cause of death?
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To the within 2 To the comple	Σ	29b. Signature and title of certifier			,o.ricage		9c. License		sila pia	1, 220 10			d (Month, i	
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5/1		30. Name and address of person wh	o completed cau	ise of death (Ite	m 23a) (Type,	Print)	18/11	te	le <	H23	10	MMA	miles	SMD21401
State		31. Date filed (Month, Day, Year) FEB 2 9 2	012 32.	legistrar's Sign	ature	a de				<u>~ &gt; \</u>	,			
Registra	r	1 FD % 0 F	A	The same	14. 14	MARIA								

33 - -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 211 Physician/ Month Year Milton Vernon Beigel Jr. Medical P 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center N Be1 Air Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 215-42-6322
Usual Residence of Deceden 1 🛛 M 2 🗆 F 03/13/1944 MΤ 28a-f show the Maryland 10a. State 10b County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Ceci1 Conowingo 10e. Street and Numbe 10f. Zip Code must be 10g. Citizen of What Country? Funeral items 23a 500 Ragan Road 21918 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian. Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. "natural" Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Secondary (0-12) Structural Engineer Engineering and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ other traumatic Milton Vernon Beigel, Sr. Carrie Wyatt 19a. Informant's Name/Relationship (Type, Print) Department of Health and 2 s. Important: If item 27 is any injury or other **** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diann Beigel - wife 500 Ragan Road, Conowingo, MD 21918 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/05/12 4 Donation 5 Other (Specify) .T.Foard Funeral Home, PA Rising Sun, MD neral Service Lice 21. Signal of 22. Name and Address of Facility R.T. Foard Funeral Home, PA S. Queen Street, Rising Sun, MD 21911 23a. Part & Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sici_n disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) culas and that initiated events resulting in death) Last Due to (or as a consequence of) burial MR#800607 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page perform Yes 2 N 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 □-Yes 2 ☑No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

Director: After this of in by the funeral di 27. Manner of Death Date of injury 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred or Attending (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 0053568 rebruara esopeak oleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con 15+1VA Jefrey HOMPSON

DHMH 17 Rev 06-2011

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

łanna Gabrielle		99 Si 1- For State Registrar	ate of Ma	ryland /		artment o <i>rtificate o</i>			Menta	al Hygi		eg. No. 2 (		2 0	846
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		13358 Glissans Mill R		id fidifiber)			Mt. A		ocation of t	Death		Frederick			
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. I	last birthday)	If Und	ler 1 Year	If Under 2	24Hrs. 8.	Date of Bir	th(MM/DD/YYYY)	9. Birt	hplace (State	∋ or
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eath v	Funeral	1 X Never Married 2 M	anned	ed Forces?	K No				Mexican, P			White,	etc.		
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MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	입	19a. Informant's Name/Relations	hip (Type, Print	•		AC.	_	(				nber, City or Town			- 6
	-	Patricia Bragg 20a. Method of Disposition	/ Mother	<u> </u>	[ 20h	P. O. Place of Dispos	Box	26, 1	Wacha	preas Da		/irginia			
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687 ertific ding p e as th	au	23b. Was decedent pregnant in the past 12 months?	1.00	ive birth			etal death	3 [	Ectopic p	regnancy		Month	D	ay	Year
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FSFS	ž	29b. Signature and title of certific					29	c. License				29d. Date signe			)
		famile Tout	faell, mi					O.C.M	.E.			February 24	, 2012	2	
5		30. Name and address of person Pamela E. Southall, N		cause of dea		,	) W/ B	altimore	Street F	Saltimor	e, MD 2	1223			
Sta	ate	31. Date filed (Month, Day, Year)		2. Registrar's					J., 001, L		-, Z				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1135 PM Maran 300 Margaret Burkett Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fahrney Keedy Home and Village Washington Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sep 27, 1 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Pennsylvania 96 Director 164-34-2697 1915 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20410 Shore Harbour Drive 20874 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Whi<u>te</u> Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Apfelthaler Helen Gracek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once, Gwen Parish/daughter 20410 Shore Harbour Drive Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/06/2012 Pittsburgh, PA Jefferson Mem. Park 21. Signature of Fun ral Service Line 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike, Boonsboro, MD, 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final D. Sease ruetive Physician/ chron. Lung disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner em 5,00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examine Que to lor out a consequence of physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician requires that the death certificate be P.O. Box 68760 use as 1 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for t Month Year Day Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** To Be 26. Place of Death (Check only one) examiner? 2 AK 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOG0396 3 1126 opal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ct MD 21740 MURSHED FARID Hayarstown 31. Date filed (Month, Day State Registrar

Margaret

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:55 AM Edward Allen Baker, Sr. MARC 2012 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hagerstown Washington <u>Western Maryland Hospital Center</u> 8. Date of Birth (Month, Day, Year) March 31,1948 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 1**⊠**M 2□F Months Days Maryland 63 220-42-5612 Usual Besidence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 No Williamsport Washington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21795 USA 121 South Artizan St. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Leather Manufacturer Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David A. Baker Betty M. Mellott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 121 South Artizan St. Williamsport, Maryland 21795 Rosalie Baker - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park March 6,2012 Hagerstown, Maryland 21. Signature et Funeyal Service Licensee 21795 OSBOTTE ATTENDED HOME, P.A. 425 S. Conococheague St. Williamsport, Maryland Arant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YEARS ARTERIOVENOUS MALFORMATION Due to (or as a consequence of) STATUS POST TRACHEOSTOMY ESPIRATORY MAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

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Completed

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Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Marýland 21215-0036

Baltimore,

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burial-tran physician the for use ģ certificate has page funeral director this

After

124 hours after death.

Pe Funeral Director; A pletely filled in by the fu

or Attending

Hospital

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

performs

25. Was case referred to medical examiner? 2 No 1 ☐ Yes 27. Manner of Death

29b. Signature and tine of certifier

E

5 ☐ Pending investigation

6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Other: 4XI Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARCH

death? 1 ☐ Yes

2□ No

2012

29a, Certifier

PAULIN

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1500 Pennsylvania Avenue Hagerstown, Maryland 21742

00062895

26. Place of Death Check onl one

completely To the I within 2.

> 31. Date filed (Month, Day, Year) State Registrar

IW-3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ethel Cox 4:25 РМ February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months 06/14/1923 Marviand 88 Director 218-12-9194 Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Examiner must be notified at Funeral Director 1 Yes 2 No Prince Frederick Calvert Maryland 10f, Zip Code 10g. Citizen of What Country? 0 10e. Street and Number items 23a United States 20678 105 Stoakley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes Give Specify Specify: 3XX Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Security Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Ethel Maud Rawlings William Edward Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Stoakley Road Prince Frederick, Maryland 20678 Maurice Cox / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 03/05/2012 Huntingtown UMC Cemtery Huntingtown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, PA Signature of Funeral Service Licensee 4405 Broomes Island Road Port Republic, Maryland 20676 Kyle S. Simons MO1206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to him solution cause. Enter Underlying Cause (Disease or iinjury Examine Dee to for sels consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? this certificate has death? 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After work?
1 Yes 2 No Natural Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 201 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) 5 Jonathan Lowenthal, MD 110 Hospital Road, Suite 310 Prince Frederick, Maryland 20678

Registrar

State

31. Date filed (Month, Day, Year)

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 12:03 A^M **February** Monica E. Covey Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Valley Nursing Home Rockville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** Hours Min Director 015-20-9945
Usual Residence of Deced 1 🗆 M 2 🗶 F 86 November 16,1925 Massachusetts show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 28a-f 1 Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral 20850 1235 Potomac Valley Road United States ural", or items? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 X Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 Specify: Caucasian 1 Yes 2 No Specify: 27 is marked other than "natural", traumatic event, the Medical Exal 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Worker Federal Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Monica Sullivan Gilbert Covey 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sigrid Haines, Guardian 3 Bethesda Metro Center #460, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Fort Lincoln Crematory 3/7/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MO1102 22. Name and Address of Facility Simple Tribute 21. Signatur of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Donset and Death

days Immediate Cause (Final disease or condition Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Dementia vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burrel-trasil Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical certificate be Box 68760 use as the attending IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes Other: 2 **X** No 4 X Nursing Home 5 Residence 6 Other (Specify ٥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending Fafter death. Director: After 5 Pending work? 1 ☐ Yes 2 ☐ No X Natural M Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral D Hospital Medical

State Registrar

DHMH 17 Rev 06-2011

FC

29a. Certifier

only one 29b. Signatur

3

31. Date filed (Month, Day, Year)

d title of certifier

Amurita Mendhiratta,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9043 Shady Grove Court, Gaithersburg, Maryland 20877

29d. Date signed (Month, Day, Year)

February 27, 2012

29c. License number

D38262

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		d Mental Hygiene
			Registrar	rtificate of Death	Reg. No. 2012 0816
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month  Pebruary 27, 2012  3. Time of Death  6:55 P
	Medic	al	Christos Christopoulos		
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	eath 4c. County of Death
	Funeral		Johns Hopkins Bayview Care Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Baltimore If Under 1 Year   If Under 24 H	Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		216-32-0293 1 M 2 □ F 81 Yrs.	Months Days Hours Mi	
	A		Usual Residence of Decedent		0,20,1300
	f sho	햦	10a. State 10b. County 10c. City, Town or Li		10d. Inside City Limits
2	28a-	ire	Maryland Anne Arundel Crof		1 ☐ Yes 2 ☒No
	3a or	al	10e. Street and Number	10f. Zip Code 21114	10g. Citizen of What Country?  USA
	ms 2	Funeral Director	1704 Tarleton Way  11. Marital Status  12. Was Decedent Ever in U.S. 13.		
	or ite	by Fi	11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S. Armed Forces 1 □ Ves 2 ☑ No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put	(Specify Yes or No- erto Rican, etc.)  14. Race - American Indian, Black, White, etc.
900	ral",	ad be	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:	Specify: White
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ylarıd	and 2 should be med within 7. hours after death with the maryantor. Health and Mental Highere.  Health and Mental Highere.  tem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	일	17. Father's Name (First, Middle, Last) Bill Christopoulos		Name(First, Middle, Maiden Surname) Joanna Karavedas
<u> </u>	mark matic				Rural Route Number, City or Town, State, Zip Code)
Z	27 is		T		Crofton, MD 21114
ָט ע	perform rage I and 2 should be lines within 72 hours after death with the waryand Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disp	osition (Name of	Date 20c. Location - City or Town, State
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parimore	Departing Departing Importa any inju				George P. Kalas Funeral Home
۵			Krof. Kalao		sland Rd. Edgewater, MD 21037
			23a. Part 1/Enter the disease or complications to t caused the death. Do not en shock, or heart failure. List only one cause of each line.	ter the mode of dying, such as cardi	liac or respiratory arrest, Approximate Interval Between
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	Medical xaminer		resulting in death)  Due to (or as cons-wence of):	1	
Н		e.	Sequentially list conditions, b. Neuron (Sequentially list conditions)	-aulue	- 1 charles
70	sit	ш	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Unsease or impary)		
4	and al-trar	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):		
200	attending physician and for use as the burial-transit	dical Examiner	L _d		
070	g phy as the		I STANLE		
, 00 X	endin use	an/l	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	Ectopic pregnancy	23d. Date of delivery
מַלְּבַּלָּ	he att	Physician/Me		Other (specify)	Month Day Year
<u>:</u> ز	d by t	P.	Part II/Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
, 4 , 4	signer	Completed by	hunortention	and anything cause given my earn	1 Yes 2 No 3 Probably 4 Unknown
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מ מ	has l	dm.			<ul> <li>autopsy prior to completion of cause of</li> </ul>
ב ב	ficate or, pa		25. Was case referred to medical	26. Place of Death (C	1 Desk only and
VILA	s cert	To Be	examiner? 1  Yes 2  IOlo  Hospital: 1 Inpatient 2  ER/Outpatie	_ Other: _	g Home 5 ☐ Residence 6 ☐ Other (Specify)
5	er thi		27. Manner of Death 28a. Date of injury 28b. Time of	f 28c. Injury at	28d. Describe how injury occurred
5	or: Aft	fica	2 Accident Investigation	work? 1 ☐ Yes 2 ☐ No	
VISION	ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
בֿ בֿ	urs at				
1	Fune Fune	edical		stigation, in my opinion, death occurre	ed at the time, date and place, and due to the cause(s) and manner state
4	within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 Scertifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and	place, and due to the cause(s) and manner as stated.  29d, Date signed (Month, Day, Year)
	> F 0		Keplandy Tournha ) CRAP	K0046	64 Flanuary 27101)
	.		30. Name and address of person who completed cause of death (Item 23a) (Type,		41 14Mary 40 1, 2012
1	rle			ayview Circle, B	Baltimore, MD 21224
	Stat		31. Date filed (Month, Day, Year) FEB 2 9 2012 32. Registrar's Signature	back	
	Registra	1	LED HO FAIR DENOUS IN	32.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Theresa Mae Christensen Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl **Examiner** BAKIMORE WASHINGTON MEDICAL ENTER CHEN ISURNIB AMME Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 134-16-0217 **Director** 1 🗆 M 2 🗶 F 86 July 20,1925 Georgia Usual Residence of Deced the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Anne Arundel Pasadena 28a-f 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö ms 23a or Funeral 21122 1530 Park Lane USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2X No Specify White th and Mental Hygiene.
27 is marked other than "natural", traumatic event, the Medical Exa Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Education Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Sutton Maude Batsford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 1530 Park Lane Pasadena, MD 21122 John Christensen III/ Son Department of Healti Important: If item 2 any injury or other tonce. other 1 Baltimore, 20a. Method of Disposition Date 27, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. 2. 2012 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Signature of Fineral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DISEASE Death Immediate Cause (Final TULMOWAR Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Day Pregnant at time of death 5 Other (specify) Month Year ed by the a Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 No tor; After this certificate has the funeral director, page 2 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 0 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director; 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner To the best of my movie generations at the time, date and place, and the name (n) and manner as interest. the 29b. Signa title of certifie pleted cause of death (Item 23a) (Type, Print) of person who cor

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Registrar

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			Registrar  1. Decedent's Name (First, Marchael Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Cont	Aiddle Loc	s#1		Cer	tificate o	Death		2. Date of De	Reg. No.	112	118469	
	Physicia		Norma R. Ca	-	,			Month 02				Day Vear		3. Time of Death 2:45 PM	
	Medic Examin		4a. Facility Name (if not insti-	ution, give	street and number)			4b. City, Towr		n of Death		4c Counts	of Death	1 1	
			Heritage Har					Annap		. 0717			Anne Arundel		
	Funeral Director		5. Social Security Number 218-20-1350	6. S	ex □ M 2 <b>∑</b> F 7. A		ast birthday) 01 Yrs.	Months Day		er 24 Hrs. Min.	8. Date of Bird (1/2/1/29	"/" <b>1</b> 910	9. Birthp Coun	place (State or Foreign try) DC	
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	larylan <b>3a-f sh</b> ified a	Funeral Director	MD Anne Arundel Davidsonville								1 Yes XX No				
	the Manager	ä	10e. Street and Number					10f. Zip Cod	е			10g. Citizen of	ntry?		
	th with ms 23 must	iner	3704 Tanglew	ood L		- 1 H	140.1		21035				USA		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐</li><li>3 ☒☒/Idowed 4 ☐ Div</li></ul>		1 Yes 2XXNo		Was Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.)  □ Yes 2★★No Specify:			city yes or No- Rican, etc.)		ce - Americ ck, White, W			
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Maryland 2	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "fraumatic event, the Med	To Be	17. Father's Name (First, Mic Leslie Rowe	dle, Last)					18. Mo	ther's Name		Maiden Surnam	re)		
	and 2 should Health and N tem 27 is ma ther trauma		19a. Informant's Name/Rela Linda Sands	tionship (T		hter						r, City or Town, S Ville,			
Baltimore,	Page 1 ar nent of He a <b>nt: If iter</b> ury or oth		20a. Method of Disposition			e C	emetery, cren	sition (Name of natory or other p		3/2/	Date 2012	20c. Location  Davidso			
Balti	permit. Page 1 a Department of F Important: If ite any injury or of		21. Signature of Funoral/Ser	vice Licens	see///	•	22 H	Name and Ada	Fune	ilibr		12 Rid Annapo	gely lis,M	Ave D 21401	
本	Physician/		23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final disease or condition	se, or com List only o	plications that causine cause on each li	ed the deat ne.		er the mode of o	ying, such a	as cardiac c	r respiratory ar			Approximate Interval Between Onset and Death	
F	Medical Examiner		resulting in death)  Sequentially list conditions,	ſ	Due to (or as	a consequ	uence of):								
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09	te be executed hysician and the burial-transit	dical Examiner	resulting in death) Last  Due to (or as a consequence of):  d.												
Box 687	ith certifica ittending p or use as 1	/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 — Yes 2 1 No g — Unknown		23c. If yes, outcom 1  Live Birth 4  Pregnant g  Unknowr	2 Feta	al death 3	Ectopic pregn Other (specify			23d. Date of de Month			ery Day Year	
s, P.O.	ires that the dea signed by the a d be detached f	by	Part II. Other significant co	nditions c	ontributing to death	but not res	ulting in the u	nderlying cause	given in Pa	ert I.				ne cause of death?	
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H	ician: The certificate rector, pag		25. Was case referred to me	dical				26	. Place of D	eath (Check		2 No	1 🔲 Yes	2 🗆 No	
of Vital	ysician: nis certific director,	To Be	examiner?		Hospital:	tient 2 🗆	ER/Outpatier	1	Other:	/		dence 6 🗆 Oth	ner (Specify	r)	
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Division	Hospital or Attendi 24 hours a er death Funeral Director A eted filled in by the f	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28b. Time of injury at work? 1 Yes 2 No 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr 28d. Describe how injury occurr								er or Rural	Route Number,				
	To the Hospital or A within 24 hours a er To the Funeral Direct completed filled in by	Medical	(Check 2 Meconly one) 3 Cert	ical Exam ifying Nur	sician: To the best of iner: On the basis of se Practioner: To th	examination	n and/or inves	tigation, in my or death occurred a	inion, death t the time, d	occurred at ate and plac	the time, date a	and place, and du	ie to the ca	use(s) and manner stated.	
	To the within 2 To the comple		29b. Signature and title of co	ertifier	(Ruf			29c. Lice	R (04	A		29d. Date signe	7 / 12	Day, Year)	
7,	117		30. Name and address of pe	rson who	completed dause of	death (Item	1 23a) (Туре, F	Print)	ilevar	d Su	ite B	Glen Bu	rnie	,MD 21061	
*	Sta	te	Diana Ng 31. Date filed (Month, Day, Y	0 2 2	019 32. Regis	trar's Signa		60.41							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Florence Corbett 2012 Medical <u>February</u> 9:15 P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health Annapolis Anne Arundel Social Security Number 6. Sex . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 1, 1918 **Funeral** 9. Birthplace (State or Foreign Months Hours Director Pennsylvania 189-05-1067 93 Usual Residence of Decedent J2 should be filed within 72 nous and alth and Mental Hygiene.
n 27 is marked other than "natural", or items 23a or 28a-f shown 27 is marked other than "natural", or items 23a or 28a-f shown 27 is marked other than "natural", or items 23a or 28a-f shown 27 is marked of the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Odenton 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8603 Wintergreen Court. # 405 21113 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 X Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Seamstress</u> Clothing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Unknown Bugjo Victoria Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Roski/nephew 8603 Wintergreen Ct. # 405, Odenton, MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2X Cremation 3 Removal from State Metro Crematory 3-1-2012 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD ignature of Funeral Aervio Licer Marine and Address of Facility Beall Funeral Home Q.A NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Due to (or as a consequence of): ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached the s been signed by t should be detach Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? Yes 1 Yes 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No s after death. I Director: After t 28d. Describe how injury occurred Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

State

Medical

completed

Registrar

. Name and address of

29a. Certifier

only one) 29b. Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 25 per med cert G925 3722/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Catherine Jeanette Cole 10:25 M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20009 Rosebank Way Washington Hagerstown 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 A F Days Hours ^{ear)}1923 Maryland 219-14-8610 88 **Director** Jsual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20009 Rosebank Way 21742 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Time Keeper Aircraft Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Wesley Hudson Norman Eva Lena Poffenberger permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Cole (Son) 17530 Stone Valley Drive Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Greenlawn Mem. Park March 7,2012 Williamsport, Maryland 4 Dopation 5 Dother (So 21. Sign Ture of F neral S 22. Name and Address of Facility Osborne Funeral Home P.A. 21795 425 S. Conococheague St. Williamsport, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter Approximate Immediate Cause (Final Onset and Death Physician/ PNEWY ON, A disease or condition Medical resulting in death) Examiner ROKE Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events HYPERTENSION STEN0415 burial-transit Due to (or as a consequence of resulting in death) Last COPP attending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ page 2 should be OFTEOPOROSIS Records, 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? MYOSITTS 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Certificate: To Be examiner? 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 2 Acciden 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as state. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TW-10

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month March 4, Melissa Ann Cole 2012 9:22 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 18832 Sandy Hook Road Knoxville 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 43 213-08-2311 Director West Virginia July 1, 1968 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be accounted. 10h County 10c. City, Town or Location 10d. Inside City Limits MD Washington Knoxville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18832 Sandy Hook Road 21758 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Inserter Private Mailing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Robert Cole, Sr. Constance Delores Tribby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Cole - Sister 18832 Sandy Hook Road, Knoxville, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 X Removal from State Fairview Lutheran 3-9-2012 4 ☐ Donation 5 ☐ Other (Specify) Bolivar, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moogoo Eackles-Spencer & Harpers Ferry, WV & Norton old L. Funeral Home 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24a. Was an . Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed? 1 Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

JW-4 State

DHMH 17 Rev 1/2001

Registrar

many

31. Date filed (Month, Day, Year)

Street Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 MD

32. Redistrar's Signature

ESKUNDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/11/2012 Virginia Elizabeth Cross 18:56 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol1 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Hours **Director** 216-22-9943
Usual Residence of Decedent 1 □ M **2**√□ F 84 04/21/1927 MD 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** notified MD 1X Yes 2 ☐ No Carroll Westminster 10e. Street and Number o 10f. Zip Code 10g, Citizen of What Country? be ms 23a o must be USA 412 Poole Road, Apt. 21157 ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XXIo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes XX No Specify. Specify: White "natural", XX Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) er than the Me Elementary/Secondary (0-12) College (1-4 or 5+) cook nursing home event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental I item 27 is marked o other traumatic eve ဂ္ဂ Myrl Utz Naomi Dull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene Bowen, son 267 High St., Willimantic, CT item 2 06226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date o Burial 2 Cremation 3 Removal from State = 5 Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Garden 03/15/2012 Finksburg, MD 22. Name and Address of Facility Pritts Funeral Home and Chapel 21. Signature of Funeral Servi Mach! 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line O et and De Interval Between Immediate Cause (Final disease or condition resulting in death) Ph_sician/ OPDEM Medical Examiner use lage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury NIDOM trans and that initiated events resulting in death) Last Due to (or as a consequenc attending physician a Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 1 Yes 2 No 9 Unknown ate has been signed by the a page 2 should be detached nditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obes 6 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Oct re low 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After it 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowle ceath occurred at the time, date and place, and due to the cause(s) and manner as stated.

For investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the Dasis of Section 3 Certifying Nurse Practitioner: To the best nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 137949

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2012 William George Chadwick 0355 АМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Ceci1 Union Hospital E1kton Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Vonths Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F JAN 27. Director 220-14-2660 88 Maryland Ĩ′924 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Marvland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5A Ernies Lane 21921 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Chadwick Mary Louise Schoen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Asbury/Daughter 3A Ernies Lane, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State March 12. 4 ☐ Donation 5 ☐ Other (Specify) Newark Cemetery 2012 Newark, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical as a consequence of: Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury ens:01 the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last 1. Kely Conneed Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has become a funeral director, page 2 s autopsy performed 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 1-Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours afte the Funeral Dire πpleted filled in t Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2

To the I

comple only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year,

SM

State Registrar 32. Registrar's Signature

70. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KtRON MA 21921

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg 2. Date of Death	. No. 4 U 1 4	2 0 8 4 7 5 3. Time of Death
	Physicia Medic		Edward Dudik		February	[™] 25, 2012	
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	Funeral		Necitas Assisted Living Home  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Silver Spr  If Under 1 Year If Under 24 Hrs.	LNG 8. Date of Birth		tgomery thplace (State or Foreign
	Director		302-14-5249  Usual Residence of Decedent  1 □ M 2 🗓 F 88 Yrs.	Months Days Hours Min.	(Month, Day, Ye 08/11/1	ar) Cos	Ohio
	land show dat	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
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Maryland 21215-0036	should be filed o and Mental Hy, is marked oth raumatic event	To B	17. Father's Name (First, Middle, Last)  John Dudik	l 18. Mother's Name	e (First, Middle, Maid Mary S	,	
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Baltimore,	permit. Page Department Important: I any injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	oln Crematory: 03/0 22. Name and Address of Facility Hin	5/2012   B	rentwood, i Funeral	Maryland Home Inc
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. Box	requires that the death certificate be executed been signed by the attending physicial and should be detached for use as the burial threat	Physician/Me	1   Ves 2   No 9   Unknown   Unknown   Tender   Ves 2   No 9   Unknown   Tender   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves 2   Ves	Other (specify)		Month	Day Year
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Division of	ding Ph h. After th funeral	Certificate:	27. Manner of Death  1 🔀 Natural 5 🗆 Pending  28a. Date of injury (Month, Day, Year) injury	of 28c. Injury at work?  M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	<i></i>
SIO	Atten	rtific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, si		28f. Location (Street	and Number or Run	al Route Number,
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	In the Hospital or Attending Physician: Within 24 hours after death of the Funeral Director. After this certification pletely filled in by the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director director, the funeral director director director director director.	Medical	29a. Certifier (Check 2	stigation, in my opinion, death occurred at	the time, date and pl	ace, and due to the c	ause(s) and manner stated.
_	with com		29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	5+1		David K. Sherr, M.D	D67355		February:	25, 2012
	_		30. Name and address of person who completed cause of death (Item 23a) (Type,  Daniel Kenneth Sherk, M.D., 1500 For	*	lver Spri	ng, Maryl	and 20910
	Stat Registra	e ir	31. Date filed (Month, Day, Year) MAR 02 2012  32 Registrar's Signature	nes		3 50	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Benjamin Saquin Durias February 2012 07:30 M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 339-90-1384 83 1 🕅 M 2 🗆 F MAR 17, 1928 Philippines Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 X No Montgoemry Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1344 Travis View Court 20879 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black White, etc. Pacific 1 Never Married 2 Married If Yes, Give Year or Dates Specify: Islander 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Durias 01iva Saquin 19a. Informant's Name/Relationship (Type, Print) Grand-Anne Durias / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1344 Travis View Ct., Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State cemetery, crematory or other place) 03/05/2012 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD Signature of Funeral Savare Licenses 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. M00956 Park Avenue, Gaithersburg, 23a. Furt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ischemic colitis disease or condition resulting in death) Due to (or as a consequence of) septic shock Sequentially list conditions

Physician/ Medical Examiner For State Registrar

10a. State

MD

Physician/

Medical

**Examiner** 

**Funeral** 

Director

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"natural", or items 23a

and Mental Hygiene.
Is marked other than "naturaumatic event, the Medical

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

must be notified at

Director

Funeral

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Completed

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with the Maryland

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours all er death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician s the buria Physician/Medical þ Completed Be ဂ္ Certificate: filled by the

Division of Vital Records, P.O. Box 68760

Lause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	c. Due to (or as a consequence of):  d								
FEMALE:  3b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Date of deliv   23d. Da									
ert II. Other significant conditions co	23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown								
	24a. Was an autopsy performed?  1 □ Yes 2 ☑ No								
5. Was case referred to medical examiner?	26. Place of Death (Check only one)								
1 ☐ Yes 2 ☐ No	Hospital:  1 Aunpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
7. Manner of Death  1		28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
9a. Certifier 1 Certifying Phys (Check 2 Medical Examir	ician: To the best of my knowledge, death occurred at the time, date and place, a ner: On the basis of examination and/or investigation, in my opinion, death occurred a	and due to the cause(s) and manner as stated.  at the time, date and place, and due to the cause(s) and manner stated.							

3 🗆 Certifying Nurse Practitiopper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who complete cause of death (Item 23a) (Type, Print), Print, Pockville, Mary land 20850 Mehrdad AKlashi, MB 9901 Medical Center Drive, Rockville, Mary land 20850

D060473

29d. Date signed (Month, Day, Year)

February 29, 2012

State Registrar

Medical

only one) 29b. Signature and title of gertifier

DHMH 17 Rev 1/2001

			AMEND #26	Plea PER	ise Type VERBAL .	or Pri	i <b>nt in</b> 6/27	Black Ir	ndelil	ole Inl	k. Ens	ure A	II Copie	s Ar	e Legi	ble.	
			For State Registrar		Stat	e of M	larylar			nt of F te of E		and M	fental Hy		20	112	081.78
			Decedent's Name	e (First, Middle	e, Last)				imod	10 01 2	- Catin		2. Date of D			/_ 8 h	3. Time of Death
	Physicia Medi		Betty	Lo		step							Februa	ry 2	³ / ₇ , 20	12	8:56 A.™
	Examir	er	4a. Facility Name (if			,			4b. Cit		Location			4	c. County o		1 1
	Funeral		Anne Ar 5. Social Security N		6. Sex	7. Ac		last birthday)		er 1 Year		24 Hrs.	8. Date of Bi		9. Birthplace (State or Foreign		
	Director		218-42-5 Usual Residence of	18-42-5196 1□M2∏F 68					Months	Days	Hours	Min.	027267	194	4 ]	Mary	land
	show dat	tor	10a. State	10b. County			10c. Cit	ty, Tow <i>n</i> or Loc	cation							1	0d. Inside City Limits
	e Mary 28a-1 notifie	Director	MD		Arundel			Loth									1 ☐ Yes 2 🚺 No
	vith th		10e. Street and Nun 5718 Br		ooda Poo	1			10f. Z	ip Code	20711			10g. C	itizen of W		try?
	eath v tems er mu	Funeral	11. Marital Status	OOKS W	12. Was I	Decedent	Ever in U.	J.S. 13. Was Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto F			cify Yes or No	_	U.S.		an Indian.		
Baltimore, Maryland 21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Marri 3 ☐ Widowed		If Yes	d Forces? Yes 2 X , Give or Dates.	No		Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2 ☑ No Specify:					white, e	etc.		
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212	iled within I Hygiene. other thai		Elementary/Second 12		Colleg	ge (1-4 or 5	5+)			se retired) ous d	river			t	ransp	orta	tion
pu	be filed ental Hye ked oth ic event,	To Be	17. Father's Name (f								18. Mothe	er's Name	(First, Middle	, Maiden	Surname)	•	
ryla	should be file h and Mental H 7 is marked or traumatic ever	-	Elmer		eland							rgar			11ing		
$\mathbf{Z}$	1 and 2 should be fi of Health and Mental item 27 is marked other traumatic ev		19a. Informant's Na  James E			and		1					Route Numbe Lothia				ode)
ore,	ige 1 and 2 s nt of Health it: If item 27 or other tra		20a. Method of Disp	osition	3 □ <b>/</b> Řemoval t		20b. F	Place of Disposemetery, crem	sition (Na	me of			Date Date	T	ocation - 0		wn, State
ţim	permit, Page 1 Department of Important: If i any injury or once.		4 Donation	5 Other (S	Specify)	rom State	Met	ropoli	tan	Crema	itory				exand:		
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		Н	23a. Part 1. Enter t	ne disease, or	complications the	hat caused	the deat								s, m	20	736 Approximate
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philips.	Medical Examiner		resulting in death)  Due to (or as a consequence of						U.S.								
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a con					uence of):	cin	uni	1						week
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3760	ficate I g phys	/ledic			d												
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 G 9 Unknown	nonths?	1 L 4 L	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5 Other (specify)						ry Day Year					
P.O.	that the dea led by the a detached f	by Ph	Part II. Other signifi	cant condition	ns contributing	to death b	ut not res	ulting in the ur	nderlying	cause give	en in Part I		23e. Did 1	obacco	use contrib	oute to the	e cause of death?
ds,	w requires that to see signed to should be dete	ted b	,			-						<u>.</u>	10	Yes 2	□ No 3	3 🗆 Prob	ably 4 D Unknown
COL	law re has be je 2 sho	Completed				_							24a. Was	psy	pri	ior to con	sy findings available apletion of cause of
R	sician: The la certificate ha rector, page		25. Was case referre	d to medical		+							1 🗌 Yes	ormed?		eath?	2 <b>4</b> No
Vita	ysicia is certi directo	To Be	examiner? .	No	Hospital:	X Inpatie	ent 2 $\square$	ER/Outpatient	+ 3 □ r	0.11	r:		only one) ne_5 □ Resi	dence (	3 Other	(Specify)	
of	Attending Physician: or death. ector: After this certific by the funeral director,		27. Manner of Death	5 ☐ Pe <i>n</i> din	28a. D	ate of inju Nonth, Day	ry	28b. Time of injury		28c. Injury work?	at		8d. Describe				
sion	or Attending after death. Director: After in by the funer	Certificate:	2 Accident 3 Suicide	Investig	not be	ace of Inju	In/ - At ho	me, farm, stre	M ot factor	1 🗆 `	Yes 2 🗆		206	044	-1.511		Dec 4. Al mate
Division of Vital Records, P.O.	To the Hospital or A within 24 hours after To the Funeral Directory Directory Illed in by		4  Homicide	determ	bu	uilding, etc	: (Specify	)					City or Tov	vn, State	e)		Route Number,
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2	Medical E	Physician: To the xaminer: On the Nurse Praction	basis of e	xaminatior	n and/or investi	gation, in	my opinior	n, death oc	curred at	the time, date a	and place	e, and due t	to the cau	se(s) and manner stated.
	Voithi Voithi Comp		29b. Signature and t				,			c. License					te signed (		-
9			19 hen	100		J .				Hoc	704	81		1-	27-	12	
)RI	03		30. Name and addre	ss of person v	vho completed o	ause of d		23a) (Type, Pr	rint)	20016	bre La	A	2001	1,0	$\alpha$	D	
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	Registra	11		4 4 5 4 4 4 4	2 (11)	1 /4	CHECKI	J 17.	1331	1 Stand							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Michael Alan Fleisher 2%, 20°1°2 312 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 11704 Enid Drive Potomac Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. . Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 578-56-3755 1 😾 M 2 🗆 F 68 06/30/1943 Ohio Usual Residence of Deced 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery MD Potomac 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11704 Enid Drive 20854 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 △ Yes 2 □ No
If Yes, Give Vietnam 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify. White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) Developer Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Milton Fleisher Etta Meltzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11704 Enid Drive Potomac MD 20854 <u>Trudy Luria Fleisher – wife</u> 20a. Method of Disposition
1 

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State King David Mem. Grdns 3/1/2012 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) M0116 22Danzandky Colliberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Pancreatic Cancer resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lect. Examiner Due to (or as a consequence or): Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician Medical **Examiner** 

attending physician and for use as the burial from

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eral Director; After this certificate I filled in by the funeral director, pag

within 24 hours a
To the Funeral C
completely filled

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Certificate:

Medical

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To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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Examiner

Medical

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permit. Page Department of Important: If any injury or

Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-1 sho

Baltimore, Maryland 21215-0036

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown

(Specify,

a. Was an autopsy performed?	24b. Were autop prior to co death?
Yes 21 No	1 🗆 Yes

b.	Were autopsy findings available
	prior to completion of cause of
	death?
	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other
27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred

I L <del>i i</del> natural	5 ☐ Pending	(117011011) Day, 10al)	11113
2 Accident 3 Suicide	Investigation 6 Could not be		
4 Homicide	determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm

1 Yes 2 No n, street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, State)

<ul> <li>a. Certifier</li> <li>1 X Certifying Phys</li> </ul>	sician: To the best of my knowledge, death occurr	red at the time, date and place, and due to the	cause(s) and manner as stated.								
(Check 2 Medical Exami	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
only one 3 Certifying Nurs	3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated										
o. Signature and title of certifier	7 . 1	29c. License number	29d. Date signed (Month, Day, Y								

D67258

Date signed (Month, Day, Year) February 27, 2012

lace, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nicholas John Farrell MD 9707 Medical Center Drive #200 Rockville MD 20850

State Registrar

31. Date filed (Month, Day, Year) 02



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Milton FREUNDEL Physician/ March 1, 2012 11:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Bethesda Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Sex 1 M M 2 □ F Age (In yrs. last birthday) 8. Date of Birth Days Hours Aug. 17, 1923 New York **Director** 88 098-14-5987 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4000 Cathedral Ave., NW #4B 20016 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates. WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ecify: white þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📶 No Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) U.S. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Foreign Service Officer State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sarah Emmer Harry Freundel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 Cathedral Ave., NW, #4B, Washington, DC 20016 Pauline Freundel, wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 03/04712 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) <u>King David Memorial Garden</u> Falls Church, VA 21. Signature of Runera Service Licenses Tở Mơn 1718 kg s Mết Tew Funeral Home 254 Carroll St., NW. Washington, DC 20012 Part 1. To the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a Part 1 Approximate Immediate Cause (Final Onset and Death Physician/ CORONARY disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 2 WNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🖁 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 P.O. Records, Hospital or Attending Physician: **Division of Vital** To the Hospital or Attending
within 24 hours after death.
To the Funeral Director: Afte
completed filled in by the fun-

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State

Medical

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Truong Bao.

determined

M.D.,

la Bow, und

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

**ORIGINAL** 

🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

10110 Molecular Drive #206, Rockville, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DOO 57129

29c. License number

28f. Location (Street and Number or Rural Route Number,

3/2/12

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day JOHN DALE FOOKS MARCH 201²2 1 11:45 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death QUEEN ANNE'S COUNTY HOSPICE CENTER CENTREVILLE QUEEN ANNE'S If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 01/06/1943 MARYLAND Director 213-42-1054 68 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MD QUEEN ANNE'S GRASONVILLE 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 116 JACKSON CREEK ROAD 21638 UNITED STATES within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 X Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is marked other thi any injury or other trains. CARPENTER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WILLIAM FOOKS MINNIE O'DONALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLENE BENTON / DAUGHTER 1825 BATTS NECK RD., STEVENSVILLE, MD 21666 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION
CENTER 03/03/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) ruf Uner rvice Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 1000 Physician) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 X No 1 🗌 Yes 1 🗌 Yes 2 🕽 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending work 1 Yes 2 No Investigation To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral L Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu certif 30. Name and address of person who completed cause 3a) (Type, Print 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Glenda Sue Grau 044 A M Morch 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospita Talbot Memoria Laston 8. Date of Birth (Month, Day, Year) June 24,1952 5. Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 459-04-4628 **Director** 1 □ M 2 🗓 F 59 Texas Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Maryland Caroline Preston 1 Yes 2X No 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5153 Frazier Neck Road 21655 USA Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic conservations. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 X Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Sales Associate Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ray Culp Winnie Baggerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winnie Culp/Mother 594 Mary Jane Street, Belton, Texas 76513 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3X Removal from State cemetery, crematory or other place 3/9/2012 Moffat Cemetery Moffat, Texas 4 Donation 5 Other (Specify, Name and Address of Facility 7eller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Nide achy cand disease or condition lex Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transif Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death in the past 12 months? Month Day Year the be detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ avolio 1 Yes 2 No 3 Probably 4 Onknown Completed should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes ည 1 Stoatient 2 🗌 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural vatural
Accident
Suic 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 20c. License number 29d. Date signed (Month, Day, Year) March 4 D0053110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

MAR 06

37. Registrar's Signature

Dennis M. DeShields, M.D., 219 S. Washington Street, Easton, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayrch 3, 1:10 A M 2012 Rose GLASER Medical 4a. Facility Name (if not institution, give street and number) c. County of Death Montgomery Examiner 4b. City, Town, or Location of Death Rockville Hebrew Home of Greater Washington . Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth g. Birthplace (State or Foreign Washington, DC 6. Sex 7. Age (In vrs. last birthday) Funeral Days Augonth, 3ay, 19914 1 M 2 TyF 97 578-62-1083 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits Director N. Bethesda 1 Yes 2 XNo Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 20852 10201 Grosvenor Place #1209 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bessie (unknown) Moses Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Glaser, Son 1029 Potlach Circle, Anchorage, AK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 M Removal from State 4 Donation 5 Other (Specify) Sholom Cemetery 03/05/12 Washington, DC 21. Signature of Funeral Service Licensee 22Toreninskyoffebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1 Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial transit Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, To the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2-1 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) sha 20061096 MD 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE ROMP, ROCKNILLE, MD2085 6121 GOLLAPALL, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR 05 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ JOHN ANTHONY GIORDANO MARCH 2012 0248 М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 54 217-74-1893 JUNE 20,1957 MARYLAND Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No MD QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 512 SPARKS MILL ROAD 21617 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married þ ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) /Secondary (0-12) BUILDER CONSTRUCTION Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL GIORDANO MARIA BOWERS and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a NICOLE GIORDANO/ WIFE 512 SPARKS MILL ROAD, CENTREVILLE, MD 21617 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or c CHESAPEAKE CREMATION MARCH 3, CENTER 2012 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) STEVENSVILLE, MD ture of uneral Sorrice Lic ise 21. Si FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) **CARDIOMYOPATHY** Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 🗶 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 **X** No ည ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗶 Inpatient 2 🗌 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif License number 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMORE 600

DHMH 17 Rev 06-2011

State

Registrar

5 2012

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont 02 2012 Joseph Gudsnuk III 0949 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne **Arundel** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours 047-34-2177 1 X M 2 □ F 67 06/04/1944 Michigan Usual Residence of Dec 10c. City, Town or Location 10d. Inside City Limits Penobscot 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 Alpine Court 04473 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Defense 05 Information Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Gudsnuk Virginia Verhey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gudsnuk 5 Alpine Court Orono Maine 04473 Spouse 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crematory 02/29/2012 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home P.A.Annapolis,MD 21401 Date 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 2 VECIV Immediate Cause (Final disease or condition Gastric Cancer resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery

Physician/ Medical Examiner

attending physician and for use as the burial-tran

ed by the a detached f

eral Director: After this certificate has filled in by the funeral director, page 2:

Physician/

Medical

10a. State

Maine

**Examiner** 

**Funeral** 

Director

at

or 28a-f st notified

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alth and Mental Hygiene. 27 is marked other than "natural", or items 23a or r traumatic event, the Medical Examiner must be

item 2

permit. Page 1
Department of Important: If it any injury or o once.

Completed by Funeral Director

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Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by To Be

IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 L Yes 2 L 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 🔀 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Parkway,

2012

Annapolis, Md. 21401

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of the Funeral Director.

Division of Vital Records, P.O. Box 68760

Selonich, mo 31. Date filed (Month, Day, Year) MAR 02 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Stuart

DHMH 17 Rev 06-2011

DHMH 17 Rev 7/2009

Registrar

arks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMENDED 15 a PEREMAN SHOULD KNOW A CONTROL OF Health and Mental Hydians

			AMENDED State State Registrar		artment of F tificate of L		,	001	12 0010-
			Decedent's Name (First, Middle, Last)		timodio or E	704117	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia Medic		Sharon L. Guyer				Month Februa	ary 28, 20	12 12:25 P.M
***	Examin	er	4a. Facility Name (if not institution, give street and number)  Kline Hospice House			Location of Death		4c. County of De	
TO SECOND	Funeral			(In yrs. last birthday)	Mount If Under 1 Year	Airy If Under 24 Hrs.	8. Date of Birt	Freder	ick Birthplace (State or Foreign
b	Director	Director 363-40-3712 1 M 2 XF 70 Yrs. Months Days Hours Min. (Month, Day, Year) Sept. 23, 1941						(Year)	Country)
	d iow it	_	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Loc	antion		Jept. 2	9, 1941 M	ichigan
	arylan a-f sh fied a	Director	Maryland Frederick						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Ma or 28	Ä	10e. Street and Number	Thurmont	10f. Zip Code			10g. Citizen of What (	
	with s 23a ust b	Funeral	18 Blackford Circle		2178	8		U.S.A.	
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36	e filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 N 3 🔯 Widowed 4 ☐ Divorced	No 1	☐ Yes 2 X No		, , , , , , , , , ,		White
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Baltimore, Maryland	be filed ental Hy ked oth c event	To B	17. Father's Name (First, Middle, Last)  Earl Leonard Gronau			18. Mother's Name	e (First, Middle, I Lorrai	,	
ary	nould be find Mental se marked umatic ev		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	a Address (Street a			City or Town, State, 2	
Σ	id 2 si salth a n 27 is er tra		Teri Yanoski – Daughter					t, Marylan	
ore	e 1 ar cof He If iten or oth		20a, Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State	20b. Place of Dispos			Date	20c. Location - City of	
tim	t. Pag tment rtant: njury o		4 Depation 5 Other (Specify)	Metropoli				Alexandri	a, Virginia
Bal	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		21. Signature of Pineral Service Licens & Illiam	$\mathcal{N}$ $\frac{22}{M}$ $\frac{22}{2}$	Name and Address olesworth Ridge	s of Facility n-William ge Road.	s P.A., Damascı	Funeral H	ome nd 20872
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	hy i ian Medical		Immediate Cause (Final disease or condition resulting in death)  Asyst						Onset and Death Seconds
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	e exectoral articular		resulting in death) Last Due to (or as a	consequence of):  Obstructive	e Atelogt	naia			
760	cate be executed physician and s the burial-transit	edical	d	, bott deel v	C ACCIECT				Weeks
89	eath certifice attending p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome o					23d. Date of d	lelivery
Вох	e atte	Physician/M	in the past 12 months?  1  Yes 2  Yes 4 Pregnant at		Ectopic pregnancy Other (specify)	<i>y</i>		Month	Day Year
P.O.	it the dea by the a etached	Phy	g ☐ Unknown  Part II. Other significant conditions contributing to death bu		-1-1-1-1	anda Da III			
ري ح.	v requires that to been signed be should be detail	d by	Metastatic Non-Small Cell			en in Part I.			to the cause of death?  Probably 4  Unknown
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Division of Vital Records,	ling P	ate:	27. Manner of Death  1 X Natural 5 ☐ Pending (Month, Day,	Year) 28b. Time of injury	28c. Injury work?	'	8d. Describe ho	w injury occurred	
Siol	Attenc death ctor: y y the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injure	y - At home, farm, stre		Yes 2 □ No	ORf Location /St	reet and Number or R	uml Pouta Number
<u></u> ≥	al or / s after il Dire		4 Homicide determined building, etc.		,,,	1	City or Town		ara riodic rumper,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner	ly knowledge, death o	ccurred at the time	date and place, an	d due to the cau	use(s) and manner as s	stated.
	the L	Me	only one) 3 L Certifying Nurse Practitioner: To the	best of my knowledge,	death occurred at th	e time, date and pla	ce, and due to th	e cause(s) and manner	as stated.
	D67//2								th, Day, Year) 28, 2012
	8		30. Name and add a of person who completed cause of dea	ath (Item 23a) (Type. Pi				Tebruary	20, 2012
	Ü		Yun Oh 46B Thomas J			derick. M	aryland	21702	
	Stat Registra	е	31. Date filed (Month, Day, Year) 1 2012 32. Registrar	s Signature	arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Louise McCauley Gower March Medical 2012 4:40 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Williamsport Nursing Home Williamsport Washington 5. Social Security Number **Funeral** If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 F Months Hours Min. Year, Director 213-18-9912 90 July 17,192 Maryland Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country? Funeral 15950 Spielman Road 21795 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Completed 3 ♥ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygle Important. If item 27 is marked other any injury or other traumatic event, th <u>Account Representative</u> Journal Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Robert Earl McCauley, Sr. Mary Anna Renner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin W. Gower - Son 15347 Dellinger Rd. Williamsport, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation ☐ Other (Spe March 8,2012 | Williamsport, Maryland Greenlawn Mem. Park 21. Signature of Funeral Serv Osborne Funeral Home, P.A. 425 S. Conococheague St.Williamsport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit · Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a d be detached for g 🗌 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy performed? Yes 2 No. prior to completion of cause of death? 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 10 160 Other: မ 1 Inpatient 2 ER/Outpatient 3 DQA Nursing Home 5 - Residence 6 - Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

strar's Signature

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of Vital Records, P.O. Box 68760, completely filled in by the funeral director, Division e Funeral within 2 To the

the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 0 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S80 C MORTHGRN AVENUE HHGERSTOWN MDZ1742

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

JW-20

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For		State of Marylar				nd Mental Hy	giene		
1 - State Regis			Cer	tificate of L	Death		Reg. No. 2	12	08490
Physician/	nt's Name (First, Middle, Last)	11				2. Date of De Month	2 / Day /	Year	3. Time of Death
IVICUICAI	Name (if not institution, give st	Tatchinson reet and number)		4b. City, Town, or	Location of F		1 1 20		2020 M
Univ	ersity of Marylan		rter	Baltin	ore		4c. County of	of Death	
I ullelal	ecurity Number 6. Sex 1 5	7. Age ( <i>In yrs.</i>		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month. Da	v. Year)	Country	ce (State or Foreign
Usual Re	sidence of Decedent	JM 2   F   03	Yrs.			April 8	3, 1928	renns	sylvania ———————
aryland aryland 10a. State MD	10b. County Dorchest		ity, Town or Lo		bridge			10d	I. Inside City Limits
Dire Street	and Number			10f. Zip Code		10g. Citizen of W	fhat Country	1 Yes 2 X No	
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shoo	Enter the disease, or compli- k, or heart failure. List only one	cations that caused the dea cause on each line.	th. Do not ente	r the mode of dying	g, such as car	diac or respiratory arr	rest,	In	pproximate iterval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02/22/2012 GARY CARLTON HUNTER 7:10 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel Social Security Number Age (In yrs. last birthday If Under 1 Year Sex 1 M 2 If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min 09/14/1962 Director 217-82-1805 49 Usual Residence of Decedent 28a-f shor 10b. County 10c. City. Town or Location must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Anne Arundel Laurel 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3593 Whiskey Bottom Road 20724 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? ö þ 1X Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. 'natural", Specify: Black Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Handyman Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nd Mental F ပ္ Charles Hunter Marion Williams and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health in Item 27 Maurice Jackson/brother 3593 Whiskey Bottom Road, Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Ziron Church Cem 03/02/2012 Laurel, MD Signature | f Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Gangrene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Examir burial-t resulting in death) Last Due to (or as a consequence of): physician Physician/Medical certificate be Records, P.O. Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ó Month Day Year Pregnant at time of death signed by the a 2 No a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Diabetis type 2, respiratory failure Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Anoic encephalopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 2 🗌 No Yes 2X No 1 Yes Division of Vital To the Hospital or Attending Physician; funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After (Month, Day, Year) 1X Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) In wow. D68782 22, 2012-MO

State Registrar

Adedeji Karunwi 31. Date filed (Month, Day,

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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· ·		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death											
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. B											
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	Usual Residence of 10a. State MD 10e. Street and Nu 1 2 2 0 3	10b. County Mont mber		Hill Street  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No of If Yes, Give Yaar or Dates:  If Yes 1 Armed Forces? If Yes, Give Yaar or Dates:  If Yes 2 No or Dates:  If Yes 2 No or Dates:  If Yes 3 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes 4 No or Dates:  If Yes			Ver Spring  10f. Zip Code 20902  as Decedent of Hispanic Origin? (Specify Y'es, specify Cuban, Mexican, Puerto Rican,  Yes 2 No specify: Hondur nt's Usual Occupation (Give kind of work donost of working life. DO NOT use retired)				izen of What Co	•
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	rector	Maryland Anne Arundel	10c. City, Town	or Locat		apolis			1	0d. Inside City Limits  1XXYes 2 \( \square\) No			
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iin 72 hou ie. han "nati	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	or 5+)	(Give kind life. DO N	VOT use retired)	uring most of worki	ng		f Business/Ind				
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Page 1 and 2 should be filed nent of Health and Mental Hint: If item 27 is marked of iny or other traumatic ever		Harry Halliwell				18. Mother's Name Lola An	kinson						
	19a. Informant's Name/Relationship (Type, Print) Pamela Halliwell/wife  19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 1227 Van Buren Drive Annapolis, Maryland												
		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		y, cremate	ion (Name of ory or other place <b>Cremato</b> :	e)	Date /2012		on - City or To More,	wn, State Maryland			
permit.   Departn mporta Iny inju		21. Signature of Juneral Service Licenses		or Funeral Home									
20200		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
Physician/		shock, or heart failure. List only one cause on each line.  Interval Between Onset and Diz No CYSTIC CANCINO NA HACKLINA COUNTY Onset and Death Onset and Death Onset and Death											
Medical Examiner			as a consequence o	f):									
kecuted and al-transit		cause. Enter Underlying Cause (Disease or injury	as a consequence o	f):									
= ± = 6	<u>.</u>												
g phys		d											
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Medical Certificate: To Be Completed by Physician/Medical	y sicial i/ i	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outco 1 ☐ Live Bi 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown	ctopic pregnancy other (specify)	/			23d. Date of delivery  Month Day Year						
that th		Part II. Other significant conditions contributing to dea	the unde	erlying cause give	en in Part I.	23e. Did to	d tobacco use contribute to the cause of death?						
auires en sign						1 🗆	Yes 2 K No 3 ☐ Probably 4 ☐ Unknown						
The law requires ate has been signated page 2 should be	oldillo			24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No									
cian: T ertifica ector, p		25. Was case referred to medical examiner?			26. Place of Death (Check only one)								
hysic this ce al dire	2	1 Yes 2 No Hospital: 1 In	<u> </u>	nt 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
or Attending Phater death. Director: After the in by the funeral Certificate:	licate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	ime of ijury	28c. Injury at work?  M 1   Yes 2   No									
tal or Att		3 Usuicide 6 Usuld not be 4 Homicide determined 28e. Place of building		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
ne Hospita in 24 hours ne Funeral pletely filled	Medica	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  30a. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
To the with com		29b. Signature and title of certifier  Hale Muchine	SII 8	29d. Date signed (Month, Day, Year)  FEB 27, 2012									
4410		30. Name and address of person who completed cause STANUTY R WATKINS			,	My An	WAPULI	s mo	214	0			
State Registrar		31. Date filed (Month, Day, Year) 9 2012 32. Rgg	istrar's Signature	ha	W.				<del>-</del>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death L HOOVER Mary 10:054 February 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 200 Baybourne Drive Arnold Anne Arundel 5. Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Hours 214-34-6471 1 □ M 2 🛣 F 76 Sep. 4, 1935 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Arnold 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Baybourne Drive 21012 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 K No Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Kennon Meade Caroline Agnes Kern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Hoover/ Husband Arnold, MD 21012 200 Baybourne Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Feb. Fort Lincoln Cemetery 2012 Brentwood, MD 22. Name and Address of Facility Barranco & Sons 495 Ritchie Hwy P.A. Severna Park Funeral Severna Park. MD 211 Interval Retween COPD Onset and Death End-Stage Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Pregnant at time of death 9 Unknown

**Examiner Funeral Director** 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at death Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filled within 72 hours aft Department of Health and Mental Hyghene. Important: If item 21 is marked other than "natural", any injury or other traumatic event, the Medical Exal any injury or other traumatic event, the Medical Exal filed within 72 al Hygiene. should be file h and Mental P is marked o Physician Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran burialattending physician I for use as the buris Division of Vital Records, P.O. Box 68760 this s after death. filled in by 24 hours within 2

To the I

complete

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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4 Donation 5 Other (Specify) 21. Signature of Fundal Service Linns Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nskajapahlm.D. D0057465 2/24/12

5203 Baltmore MD 21709

DHMH 17 Rev 06-2011

10

State

Registrar

2

2835 SMITH

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapa FX. M.D

FEB 2 9 2012

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 1354 PM Edgar Leon HOWELL March Medical 3012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington **Funeral** 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 91 220-09-7731 1**X** M 2 □ F Aug. 18 1920 Maryland Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits Maryland 1 Tes 2 X No Washington Hagerstown 10e. Street and Number ò 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 16618 National Pike 21740 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Midowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working r than " Elementary/Secondary (0-12) College (1-4 or 5+) 8 0 Owner/Operator Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lee Hampton Howell Neva Goen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christy McElhaney - Granddaughter 4565 Northwest 24th Way, Boca Raton, Fl. 33431 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 3/10/2012 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signatule of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician 1281 disease or condition Medical resulting in death) Due (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of inding physician and use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year i signed by the at Id be detached fo Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires should 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available 24a. Was an page 2 s has prior to completion of cause of death? after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗙 No Hospital Other: |요 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) within 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)  $\mathcal{Q}\mathcal{H}$ Amsles 5/20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TW-5 edi(a State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Day Year Month 2319 onald Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Trauma Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min 219-54-2485 1 🏝 M 2 🗆 F Director 62 Dec.23,1949 Maryland ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 1201 Kuhn Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. ō δ 1 Never Married 2 Married X Yes 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1969-89 er than "natural", the Medical Exa Specify: Completed 3 Divorced 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) state of Maryland maintenance officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jesse Ann Spitler James Edward Hutson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. 1201 Kuhn Avenue, Hagerstown, Maryland 21740 Kathy M. Hutson - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem.Park 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/6/12 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig Name and Address of Facility MINNICH FUNERAL HOME 5 E.Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Small Bowel Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Day Year Pregnant at time of death been signed by the sahould be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical

Box 68760 P.0. Records, Director: After this certificate Division of Vital filled in by the funeral director, 24 hours

Baltimore, Maryland 21215-0036

IW-8+1 State Registrar

within 2

To the

Khanjan Nagarshoth 31. Date filed (Month, Day, Year

d title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

only one)

29b. Signature ar

29d. Date signed (Month, Day, Year) 3/5/12

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

101388

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ Year JOYCE Α.  $\mathbf{a}^{\mathsf{M}}$ HALL MARCH 5:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 40 Bay Blvd. Earleville Cecil 5. Social Security Number Date of Div. (Month, Day, Yes 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Michigan 8 Date of Birth **Funeral** 1 M 2 F Months Days Hours Min Director 372-30-0643 80 1931 Apri] Usual Residence of Decedent 28a-f show 10c. City. Town or Location must be notified at 10d. Inside City Limits Director PA Delaware Newtown Square 1X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 127 Beechwood Rd. 19073 U.S.A. ו "natural", or item ledical Examiner ה 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3x Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Brigstock Catherine Penrod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hall (daughter) 9953 Hardy Rd. Philadelphia, PA. 19115 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Stephen's Cemetery 3/9/12 4 Donatton 5 Other (Specify) Earleville, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech ture of Fundral Service M00510 118 West Cross St. Galena, MD. 23a. Per . E. fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immedia: Cause (Final disease for condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last certificate be executed and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No page 2 should be detached for 4 Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: Summer Home ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1X Natural injury work? 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

Shahnawaz Khan,

31. Date filed (*Month*, *Day*, *Year*)

NAR 1 9 2012

M.D

2533 Augustine Herman Hwy. Chesapeake City, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 12 Day 2012 6:00 P Madeline Elizabeth Hiatt Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Taneytown Lorien @ Taneytown Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min (Month, Day, Year) Director 1 □ M 2 💢 F 219-12-0592 88 MD 07/20/1923 Usual Residence of Decedent show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f Yes 2 No Westminster Carroll MD 10e Street and Number 10f. Zin Code ō 10g. Citizen of What Country? items 23a or ner must be r Funeral 21158 USA 205 St. Mark Way, Apt. 422 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forc Black, White, etc. ö 1 Never Married 2 Married þ 2X No Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural", 3 Divorced 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than "I
r traumatic event, the Med within 7 Elementary/Secondary (0-12) College (1-4 or 5+) public schools teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sarah Elizabeth Loque Jesse David Myers, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 21158 205 St. Mark Way, Apt. 422, Westminster, MD William G. Hiatt/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 03/17/2012 Westminster, MD . Signature of Funeral Service Licenses 22. Name and Appendicular Funeral Home and Chapel, P.A. Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Physician) disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of burial-transi Due to (or as a consequence of) resulting in death) Last physician Physician/Medical requires that the death certificate be P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No P Month Day Year Pregnant at time of death signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2  $\square$  No 1 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: _2 **X** No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? after death.

Director: Al 2 No by the f Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, H0061206 30. Name and address of person who completed cause of deat m 23a) (Type, Print) Rd. Westminster roole

Registrar

State

Day 9

2012

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#23a-IIperMD, 3/5/12; BWW, McCo Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Josefa Izquierdo 7:40 P. M 2012 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Collinswood Nursing Home Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 2,1919 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Director 219-68-6845 1 M 2 EXF 92 Colombia Usual Residence of Dece 28a-f show 10b County at 0a. State 10c. City, Town or Location 10d. Inside City Limits Director Rockville notified MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be 23a Funeral 299 Hurley Avenue 20850 Colombia items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ö þ 1X Never Married 2 Married within 72 hours after altimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Colombian Specify: White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Domestic 12 Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental His marked o permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or other. 2 pe Jose Izquierdo Unknown Nieves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat 5401 Westhard Avenue, Bethesda, MD 20816 Clara Santos/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, cremator, or other place).

Geo. Wash. University Feb. 27 2012 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) Medical Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph. i.i.n. disease or condition Medical resulting in death) a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events e burial-transit Examin and Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical that the death certificate be Box 68760 use as the IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be the Hospital or Attending Physician: The law requires Division of Vital Records, End Stage Heart Failure 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performe death? 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 Yes 2 No filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the within 7 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type

00062431

29d. Date signed (Month, Day, Year)

Ville MD 80850

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Elwood Rodney Jones 0715 AM 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F 9 125 94 955 212-72-3224 56 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Calvert 1 Yes 2 No Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1530 Cox Road 20639 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give 1 Yes 2 X No Specify Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction 10 Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Jones Eva G. Coby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorelei B. Jones-Savoy/sis. 1530 Cox Rd. Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Apol.Faith Chr.Cem 3/2/2012 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell 11451 Dares Beach Rd. 21. Signature of Funeral Service Licenses Funeral Prince Home, P.A. Fred., MD20678 Hadys a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) TRUSCON Due to (or as a consequence of) Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death Month 5 Other (specify) Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical **Examiner** Examiner

Physician/

Medical

**Examiner** 

**Funeral** 

Director

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items 23a

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"natural",

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permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once.

other traumatic event, the Medical Examiner must be notified at

**Funeral Director** 

Completed by

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical

Completed by

Be ပု

Certificate:

Medical

only one) 29b. Signature and title of ce

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

pulmonory or occlusion							1 X Yes 2	No 3 ☐ Probably 4 ☐ Unknowl	
Gross hen	-opty	518,	COPD				24a. Was an autopsy performed? 1 ☐ Yes 2 【 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
25. Was case referred to medical examiner?				ck on	nly one)				
1 Yes 2 No	Hospital:	XInpatient 2 □	ER/Outpatient	Home	e 5 Residence 6 Other (Specify)				
27. Manner of Death  1	tion (A	ate of injury Month, Day, Year)	28b. Time of injury	28 M	c. Injury at work? 1 ☐ Yes 2 ☐ No	28d	. Describe how injury	occurred	
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	28e. Pl	28e Place of Injuny. At home form street factory office					8f, Location (Street and Number or Rural Route Number, City or Town, State)		
					he time, date and place,			manner as stated.	

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

State

24 hours a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nang

Prince Frederick 100

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2012

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31. Date filed (Month, Day, 32. Registra

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Registrar